EXHIBIT D

In The Matter Of:

Dafinka Stojcevski v. County of Macomb

Gerald Shiener, M.D.

May 22, 2018

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

DAFINKA STOJCEVSKI, a/k/a STEPHANIE STOJCEVSKI, Individually, and as Personal Representative of the Estate of DAVID STOJCEVSKI, Deceased,

Plaintiffs,

vs. Case No. 15-cv-11019
Hon. Linda V. Parker
Mag. David R. Grand

COUNTY OF MACOMB, SHERIFF ANTHONY M. WICKERSHAM, MICHELLE M. SANBORN, CORRECT CARE SOLUTIONS (CCS), LAWRENCE M. SHERMAN, M.D., DAVID ARFT, NATALIE PACITTO, MONICA CUENY, RN, TIFFANY DELUCA, LPN, VICKI BERTRAM, LPN, SARA BREEN, LPN, MICAL BEY-SHELLEY, LPN, DIXIE DEBENE, LPN, THRESSA WILLIAMS, LPN, LINDA PARTON, LPN, AMBER BARBER, LPN, DEANN PAVEY, LPN, CHANTALLE BROCK, LPN, KELLY MANN, DANYELLE NELSON, MHP, OXLEY, COONEY,

HARRISON, TALOS, PINGILLEY, AVERY, VANEENOO and HELHOWSKI,

Defendants.

The Deposition of GERALD ALAN SHIENER, M.D.
Taken at 251 East Merrill Street, Suite 230
Birmingham, Michigan
Commencing at 5:08 p.m.
Tuesday, May 22, 2018
Before Mary Jo Power, CSR-1404, RPR, RMR, CRR

APPEARANCES:

ROBERT D. IHRIE
HAROLD A. PERAKIS
Ihrie O'Brien
24055 Jefferson Avenue
Suite 2000
Saint Clair Shores, Michigan 48080
586.778.7778
office@ihrieobrienlaw.com
hperakis@ihrieobrienlaw.com
Appearing on behalf of the Plaintiffs

ROBERT S. GAZALL (Appearing via telephone)
Macomb County Corporation Counsel
One South Main Street
8th Floor
Mount Clemens, Michigan 48043
586.469.6346
robert.gazall@macombgov.org
Appearing on behalf of the Defendants County of Macomb County Defendants

JOHN T. EADS, III (Entered proceedings at 5:11 p.m.)
Wilson, Elser, Moskowitz, Edelman & Dicker, LLP
17197 North Laurel Park Drive
Suite 201
Livonia, Michigan 48152
313.327.3100
john.eads@wilsonelser.com
Appearing on behalf of the Defendants County of Macomb, Sheriff Wickersham, and Michelle Sanborn

RONALD W. CHAPMAN
Chapman Law Group
1441 West Long Lake Road
Suite 310
Troy, Michigan 48098
248.644.6326
rchapman@chapmanlawgroup.com
Appearing on behalf of the Defendant Correct Care Solutions and appearing as co-counsel for Defendants County of Macomb

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Birmingham, Michigan
Tuesday, May 22, 2018
5:08 p.m.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 1
5:08 p.m.

GERALD ALAN SHIENER, M.D.,
was thereupon called as a witness herein, and after having first been duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

MR. IHRIE: Let the record reflect that this is the deposition of Dr. Gerald A. Shiener, taken pursuant to appropriate notice, and that it may be used for any purposes permitted under the applicable court rules.

EXAMINATION

BY MR. IHRIE:

Q. Dr. Shiener, I know that you've given numerous depositions in the past, so I don't think I have to go over the ground rules too much with you, do I?

A. I wouldn't think so.

Q. I'm going to ask you at the end of the dep -- if I remember; if I don't, you may remind me -- if there

are any answers that you have given that you wish to -- that you wish to modify in some respect. Okay?

A. Ask me -- ask me whatever you like. I'll do my best to answer.

Q. All right. I'm looking at your CV, and I note that you have five board certifications; is that correct?

A. I do.

Q. Will you please tell me what the significance is of a board certification? In other words, what does it mean to be board certified?

A. Well, that's a pretty broad question. Board certification was a procedure that was instituted to determine that doctors had learned what they're supposed to learn in their residency.

Now, board certification when I first started practicing medicine, was more of an academic issue. And if -- it was only necessary if someone wanted to pursue an academic career, or someone needed to demonstrate that they had some special training to take a particular job or work in a particular area.

It's become more required for hospitals and as a means of quality control, and again it demonstrates that you've learned what you were supposed to learn during your residency. And we have a process now called maintenance of certification,

where the board will monitor your study and the kind of materials you're studying to determine that you continue to be up-to-date in your knowledge base.

The board had an examination in general psychiatry and child and adolescent psychiatry, and then as psychiatry became more specialized, the board began to offer certifications with added qualifications in other areas, many of which that I've tested and passed.

Q. Has maintenance of certification replaced board certification?

A. Well, that's a fluid area. Board certifi -- you have to be board certified in order to maintain your certification, and one method of doing so is to have a doctor recertify every ten years.

The boards are now studying whether demonstrating to the board that you do continuing education, participate in certain activities across a broad range, not just reading articles or taking courses, and that may serve in lieu of recertification. There are pilot programs. Some members of --

(Off the record at 5:11 p.m.)

(Whereupon Mr. Eads entered the proceedings.)

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17:12 **(Back on the record at 5:12 p.m.)**
17:12 MR. EADS: Please continue.
17:12 MR. IHRIE: All right. Thank you.
17:12 BY MR. IHRIE:
17:12 Q. So I don't mean to misquote you, but did you say that board certification is, in essence, a way for the board to confirm that you actually learned what you learned in law school -- I mean, in medical school?
17:12 **A. No, not medical school. Residency training.**
17:12 Q. In your residency training.
17:12 **A. And the board -- the board has an assurance that you learned what you were supposed to learn, or that you've met the requirements for training.**
17:12 Q. Okay. So if you went through residency and -- are you able to decide not to become board certified?
17:13 **A. Sure. There's nothing -- there's nothing that says that a doctor has to pursue board certification.**
17:13 Q. Do you have to take an additional test?
17:13 **A. For what?**
17:13 Q. Board certification?
17:13 **A. Yeah, board certification is an examination. Yeah.**
17:13 Q. And you are board certified in -- let's see if I can locate the -- tell me the five areas that you're board certified in.
17:13 **A. Well, general psychiatry; addiction psychiatry;**

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17:13 **geriatric psychiatry; forensic psychiatry; what used to be called psychosomatic medicine, and as of January 1 of this year it's called consultation liaison psychiatry; and then I'm also certified in addiction medicine.**
17:13 Q. Do you consider yourself to be an expert in all of those areas?
17:13 **A. Well, I've demonstrated expertise, and I consider that I have that expertise in those areas of psychiatric practice.**
17:14 Q. Tell me what the amount is that you have paid -- that you have been paid, rather, by Mr. Chapman's firm or any other person or firm in this case so far, not including the thousand dollars that I just paid you.
17:14 **A. $2,500.**
17:14 Q. And are you owed any money other than --
17:14 **A. No. No.**
17:14 Q. And how does the fact that you have been paid $2,500 square with your correspondence dated January 4, 2016, which indicates that your retainer fee is $3,500?
17:14 **A. Well, excuse me then. My mistake. It was $3,500. I'm sorry.**
17:15 Q. So you've been paid the initial retainer fee --
17:15 **A. Yes. Nothing --**
17:15 Q. -- and have you used that up yet?

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17:15 **A. Between preparing this document, my September 14, 2017, report, and preparing for the deposition, that just -- that's just about covered by the 3,500.**
17:15 Q. And what is your hourly rate for this deposition?
17:15 **A. $900 for the first 90 minutes, and $500 an hour thereafter.**
17:15 Q. You wrote a report dated September 14, 2017; did you not?
17:15 **A. I did.**
17:15 Q. And did you identify in that report all of the materials that you've reviewed prior to writing that report?
17:15 **A. I did.**
17:15 Q. Were there any other materials or items other than what you listed that you used to prepare your report?
17:16 **A. I don't believe so.**
17:16 Q. Are we --
17:16 **A. I had the videos. I may have received the videos after -- afterwards.**
17:16 Q. I don't see where you have identified that you based your report on any video.
17:16 **A. No. I must have received the videos afterwards.**
17:16 Q. So your report does not contemplate your review of any video; is that correct?
17:16 **A. Oh, I don't know about contemplation. I prepared my**

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17:16 **report before I received the videos.**
17:16 Q. So no portion of your report was based upon your review of the video; is that correct?
17:16 **A. I believe that's correct.**
17:17 Q. When did you receive a copy of what we have so far called "the video"?
17:17 **A. May 26, 2017.**
17:17 Q. Is there a reason why you did not look at the video prior to looking -- is there a reason why you didn't look at the video prior to writing your report?
17:18 **A. You know, I don't recall. I don't recall.**
17:18 Q. You don't recall what?
17:18 **A. Why I didn't look at the videos, or why I didn't include my review of the videos in the -- in the September 14, 2017, report.**
17:18 Q. How much of the video have you reviewed as of today?
17:18 **A. I believe I watched -- I watched everything on this disk. I may have fast-forwarded through some periods.**
17:18 Q. And how many hours did that take you?
17:18 **A. I don't recall.**
17:18 Q. There was 240 hours of video there. Do you have any recollection of how many hours --
17:18 **A. I don't -- I don't believe I watched --**
17:18 Q. Let me finish my sentence first.
17:18 **A. I'm sorry.**

Q. Do you have any recollection of how many of those hours you observed?
A. No.
Q. You -- did you keep any notes of how many of those hours that you observed?
A. No, I didn't.
Q. Are you able to estimate how many hours of that video you observed?
A. No.
Q. And just for clarification, no observation of the video was used in writing your report, correct?
A. I think I've already mentioned that a couple of times.
Q. Did you not review the video because you felt it was unimportant to review it?
A. I don't recall why I didn't. I know that I met with Mr. Chapman, we discussed some things, I reviewed it after. I'm not sure why I didn't include in my review of the video.
Q. In a case like this, knowing that there is a video that you could look at, would it have been -- is it important for you to have seen the video prior to writing your report?
A. Oh, when you say "important," I'm not -- I'm not really sure what you mean.
I didn't think it was -- I didn't think it

was particularly pertinent to reach these opinions, and I know that some of the other documentation referred to videos.
Q. So your testimony is that you don't feel it was pertinent to give the opinion that you gave in your report; is that correct?
A. Well, I like the way I said it better. And if I'm going to be stuck with a version of what I said, I'd rather it be my version.
Q. Do you feel that your report may have been different if you had viewed the video?
A. I don't believe so.
Q. And how would you know, if you haven't viewed the video?
A. I didn't say that I haven't viewed the video, I just said that I didn't include the review of the video in the report.
Q. So the number of hours that you looked at the video, which you don't know, your testimony is, that what you did look at didn't change -- doesn't change what you had previously written prior to reviewing the video; is that right?
A. Once again, I like the way I said it better. I don't need you to paraphrase that for me.
Q. Well, I'm asking.

A. Well, I would agree with my version rather than your paraphrase.
Q. Did you look at any of the video prior to writing the report?
A. I don't recall when I viewed it.
Q. So you may have looked at the video prior, or you may have looked at the video after your report; is that correct?
A. What I said is: I don't recall when I viewed it.
Q. May we rely upon the accuracy and the truth of everything that's in your written report?
A. Well, I did everything I could to be accurate and truthful in preparing my report.
Q. Is that a yes?
A. No, that's -- that's my answer.
Q. Well, I under --
A. I did my best to be accurate and truthful.
Q. May we rely upon?
A. Well, that's up to you.
Q. Is your report a reliable report?
A. Well, I did everything I could to reach my opinions and conclusions with confidence or what you would call a reasonable degree of medical certainty. Whether you rely upon it or not is up to you.
Q. Do you believe that it's accurate?

A. I told you that I did everything that I could to report my findings in an accurate and reliable manner.
Q. Do you believe it's a truthful report?
A. Well, because it -- it contains opinions, I'm not sure how that squares with the issue of truth. It's my understanding that there's a finder of fact in this matter. I try to bring an understanding to what happened, and this is my understanding.
I don't believe that -- I don't believe that I made any misrepresentations in this report.
MR. IHRIE: Excuse me one minute.
(Off the record at 5:23 p.m.)
(Back on the record at 5:23 p.m.)
BY MR. IHRIE:
Q. Is there anything in your notes or your records, or anything in your file in this case, that will remind you -- or that you can look at that will remind you whether or not you viewed any portion of the video before you wrote the report or after the report?
A. I can't think of what that would be.
Q. Please look at page 2 of your report.
MR. CHAPMAN: Do you want to make the report an exhibit?
MR. IHRIE: It's already been marked, so...
MR. CHAPMAN: I don't think so. Has it?

THE WITNESS: It was marked and offered to me, but they didn't say anything on the record.

BY MR. IHRIE:

Q. All right. So now I'm going to ask you to look at what I've given you as Shiener Exhibit Number 1 and ask if you can identify it.

A. It looks like it's a faxed copy of my report; it looks like it's a copy of a curriculum vitae, and that goes up to 2015; it looks likes it's a January 4, 2016, fee schedule.

MR. IHRIE: All right. I'm going to ask you -- move for purposes of this deposition only to introduce that as Exhibit Number 1 and indicate that it is being introduced for deposition purposes only at this time.

BY MR. IHRIE:

Q. For the purposes of this case, Dr. Shiener, what areas of expertise that you do have are you using?

A. I don't understand what you're really asking.

Q. Well, you indicated that you're an expert in geriatrics, correct? You're board certified in geriatric psychiatry?

A. You asked me about my board certifications. I'm certified by the American Board of Psychiatry and Neurology in geriatric psychiatry.

Q. Right. And are you using your expertise in that particular area of psychiatry in this case?

A. Oh, that doesn't seem particularly pertinent to the issues in this case.

Q. Which areas of expertise in this case seem particularly pertinent to you?

A. Psychiatry, consultation liaison psychiatry, addiction psychiatry, addiction medicine --

Q. On page --

A. -- forensic psychiatry.

Q. Oh. So all of the other four, basically; is that correct? Other than the geriatric psychiatry?

A. Well, I don't see how geriatric issues are pertinent to this matter.

Q. Thank you.

Looking at page 2 of your report, you indicate on number 4, it says, "CCS Medical & Mental Health, Parts 1 and 2."

A. Yes.

Q. Can you tell me what that means, "parts 1 and 2," divide it in some sense? I'm just trying to get a clarification of what that means.

A. I think there were two PDFs. The document was divided into two PDFs.

Q. All right. So you may be calling it one and two. May we conclude that you have reviewed all of CCS Medical & Mental Health documents that exist in this case?

A. I don't know that. Hold on.

Q. To try to help you along here -- unless you want more time --

A. Wait. Just -- you've asked me a question. I'm going to answer it.

Q. Okay.

A. Well, let's see. Part 1 of that document is 54 pages, and part 2 is 62 pages. That would be 116 pages total.

MR. PERAKIS: And part 2 was how many pages?

THE WITNESS: Sixty-two. So that would be 116 pages.

Now, I don't know if that's exhaustive.

BY MR. IHRIE:

Q. Yeah, you wouldn't know that, I suppose, because you only have reviewed the materials that were given to you, I presume by Mr. Chapman's office. Correct?

A. Well, I was given some documents that were labeled "CCS records." I don't know if that's exhaustive --

Q. I understand.

A. -- for whatever reason.

Q. And where did you get those records?

A. From Mr. Chapman.

Q. Okay. And looking at the first sentence of your report, Dr. Shiener, you indicate that, and I quote --

A. The first sentence of my report.

Q. Right. Well, the first sentence on -- the first sentence after the materials that you looked at, right after number 6. The sentence that says, "I have been asked to review these documents and other -- and render opinions about the circumstances of Mr. Stojcevski's death."

Do you see that?

A. I do.

Q. So you were asked to review the documents that you've listed both on page 2, and the two sets of documents on page 1, specifically deposition transcripts and other expert reports, correct?

A. Well, there's a list that -- yeah, report's in evidence. It speaks for itself.

Q. You were asked by Mr. Chapman to review the three sets of materials that are identified: number 1, the deposition transcripts that you list, one through nine, correct?

A. That's pretty much what my report says.

Q. And expert reports one through eight, correct?

A. That's pretty much what my report says as well.

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17:31 Q. And other sets of records one through six, correct?
17:31 **A. And that's also what my report says.**
17:31 Q. Were you asked to review anything else that, in fact, you did not review?
17:31 **A. No. Or at least not to my recollection.**
17:31 Q. So you were not asked to review the videotape then of Mr. Stojcevski while he was in jail, correct?
17:31 **A. Wait a minute.**
17:31 THE WITNESS: Could you read that question again, the one before that?
17:31 (The following portion of the record was read by the reporter at 5:31 p.m.:
17:31 Question: "So you were not asked to review the videotape then of Mr. Stojcevski while he was in jail, correct?".)
17:31 THE WITNESS: That's not true. That's not correct.
17:32 BY MR. IHRIE:
17:32 Q. All right. Well, then is it correct that you were asked to review the videotape prior to writing your report?
17:32 **A. I was given the videotape, and I was asked not to review it until speaking with Mr. Chapman. I spoke with Mr. Chapman, and then I prepared the report.**
17:32 Q. Did Mr. Chapman ever ask you to review the videotape?

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17:32 **A. I don't know if he ever stated -- he told me not to review it until after I spoke with him.**
17:32 Q. And when did you speak with him?
17:32 **A. Wait, wait, wait, wait, wait.**
17:32 **Do you want to let me finish answering, or do you want to interrupt me?**
17:32 Q. Go ahead.
17:32 **A. Thank you.**
17:32 **I was provided with the -- with the videos. I was told not to -- not to view them until after I spoke with him. So it was my understanding that after I spoke with him, I was to review them.**
17:32 **And I met with him sometime over the summer of 2017. I don't recall when.**
17:32 Q. If it was your understanding that you were to review the videotape after you spoke with him, and you spoke with him in the summer of 2017, then why didn't you thereafter review the videotape prior to writing your report?
17:33 **A. I think the last time you asked me that I told you I didn't recall.**
17:33 Q. Is there any portion of your report that addresses anything that you saw in the videotapes?
17:33 **A. You know, I -- again, I -- I don't recall. I know that the video was referenced in a lot of other**

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17:33 **documents that I reviewed, and I can't tell you if I drew my conclusions from viewing that firsthand or from reading the accounts in the other aspects of the documents that I've been provided.**
17:33 Q. Have you testified in jail or prison cases before?
17:33 **A. I have.**
17:33 Q. Generally speaking -- not just jail or prison cases, but generally speaking -- what percentage of your cases -- in your cases, do you testify for the plaintiff versus defendant?
17:34 **A. I have never calculated that. Probably a preponderance for -- testifying on behalf of plaintiffs.**
17:34 Q. Do you have any opinion or -- I hate to use the word guess, but do you know how many jail cases or prison cases you've been involved with?
17:34 **A. No.**
17:34 Q. More than ten?
17:34 **A. Probably.**
17:34 Q. Your first sentence under "Overview" on page 2 you indicate, "David Stojcevski was detained."
17:34 Are you using that word "detained" as a term of art in -- with respect to jails and prisons, or do you just mean that that's where he was housed?
17:34 **A. I don't understand what you're asking.**

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17:34 Q. I think that probably answers my question, but --
17:35 **A. Then I really don't understand what you're asking.**
17:35 Q. Fair enough.
17:35 You indicate that he was detained in the Macomb County Jail on June 11, 2014, at the direction of the Roseville Police Department.
17:35 Upon what did you base that statement?
17:35 **A. A police report or something that I read in those documents.**
17:35 Q. Is it your opinion that police departments are the ones that direct for a defendant to be jailed?
17:35 **A. Oh, I think a judge directs -- well, I mean, to the extent that that calls for a legal opinion, I don't know that I can answer it.**
17:35 Q. Do you know the answer?
17:35 **A. I know that police departments have the power to arrest people, put them in a lockup or put them in a jail, and then a judge can send people to jail for a certain -- for a certain period of time.**
17:35 Q. In this case did the judge sentence him to jail, or did the police department simply take him to jail?
17:36 MR. CHAPMAN: I'm going to objection: form and foundation, and not at all relevant to anything we're here for.
17:36 MR. IHRIE: It's relevant to the accuracy

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and credibility of this report.
BY MR. IHRIE:
Q. But you can go ahead and answer.
In this case did the police department make the decision to put him in jail or did the judge?
A. Well, since he was arrested on a warrant, I would assume, not being -- not being a lawyer, not being able to give you a legal opinion, I would have to conclude that, if there was a warrant, I understand a warrant is issued by a judge.
Q. So what's your answer then?
A. Well, why don't you repeat your question.
Q. Was it the judge who placed him in jail or the Roseville Police Department?
A. Oh, that's my -- well, you mean who placed him in the --
Q. Yes. Who ordered him to go to jail?
A. Well, that's different between who placed him and who ordered him.
Q. Who ordered him?
A. Well, why don't you make up your mind. Ask me a question that I can answer, and ask it consistently. Because if you ask it one way and then ask it another way, I don't know what you're talking about.
Q. Well, let's use your word.

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Who directed him to go to jail?
A. Well, directed him; my understanding is the police department took him to the jail.
Is that what you mean by "directed"?
Q. No, I'm using your word. What did you mean by "directed" in your report? You said at the --
MR. CHAPMAN: I'm going to object. He doesn't say "directed," he says, "At the direction of Roseville Police."
BY MR. IHRIE:
Q. That's what I'm about to read.
"At the direction of the Roseville Police Department, he was detained in the Macomb County Jail."
A. No, they took him to jail.
Q. So you mean they took him to jail. They transported him to jail; is that what you're saying?
A. Well, which is it, took him or transported him?
Q. Either.
A. Well, that's my understanding.
Q. Who ordered --
A. This is all you got? This is it? This is what you want to know?
Q. Do you know who ordered him to go to jail?
A. Well, ordered --

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MR. CHAPMAN: Object to form and foundation.
THE WITNESS: Whoever issued the warrant. But again, to the extent that that calls for a legal conclusion, I don't know that I can answer that.
BY MR. IHRIE:
Q. In terms of challenging me as to whether -- Is that all you have, I would respectfully request that you just answer my questions rather than challenge me.
A. I'll do my best, but I want to understand them, and many of these questions are cryptic to me, sometimes because of the way that they're posed, and sometimes because of the obscurity of what the issue really is and what you're really asking me.
So I'm doing my best to try to understand.
Q. Please do.
A. I mean, when -- usually at the outset of a deposition I'm instructed to let you know if I don't understand what you're asking. So when I ask that kind of question, it arises out of my limited ability to understand what you're really getting at or what you mean when you pose these questions to me.
But I'll do my best to try and understand and try and cooperate with you.
Q. Looking at the second paragraph, you indicate --

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toward the end it says -- you reference Nurse Deluca, noted on the intake form that he showed, quote, obvious physical signs of drug use -- or drug abuse, rather.
Why did you put that in your report, and does it have any importance to this case?
A. I put it in my report because I read it, and it showed that -- it established the fact that a nurse did make an assessment.
Q. Well, she made a lot of assessments in her initial document; did she not? Why did you pick that one to put in your report?
A. That seemed to be the most pertinent.
Q. Is it relevant to this case, in your opinion?
A. Well, I'm not sure what you mean by "relevant."
The -- wait. The medical record does have some relevance. I draw attention to certain parts of the medical record, because they're exemplary of what happened. They form examples of what happened.
Q. Well, you carved out and put in quotation marks that the form showed -- the intake form showed that he -- that she wrote, "Obvious physical signs of drug abuse."
My question is very simple. Is that fact relevant to this case?

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17:40 **A. Well, it seemed to be, or it could be.**
17:40 Q. And in what way could it be?
17:40 **A. Well, because there are some issues about his drug use**
17:40 **and about how his drug use manifested in his clinical**
17:40 **condition, who noticed it, and what they did about it.**
17:40 **So that was one reference to his drug use.**
17:40 Q. You then note that "She recommended he be placed in
17:40 the medical detox unit." And then your next sentence
17:40 says, "He was placed in the general population on June
17:40 12, 2014."
17:40 **A. Yes.**
17:40 Q. Is the juxtaposition and the content of those two
17:40 sentences supposed to indicate that she recommended he
17:40 go to medical detox, but he was rather placed in the
17:40 general population? Is that your point that you're
17:40 making there?
17:41 **A. No, I think it just -- it establishes the different**
17:41 **places in which he was housed.**
17:41 Q. Was -- after she recommended that he be placed in the
17:41 medical detox unit, do you know if he was?
17:41 **A. I don't think he was placed immediately.**
17:41 Q. Do you think he was rather placed in the general
17:41 population?
17:41 **A. On June 12, yes.**
17:41 Q. Your next paragraph indicates that on June 17 --

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17:41 strike that. Let me ask it a little bit differently.
17:41 From June 11, which is when the intake form
17:41 from Deluca was taken, your next entry, your next
17:42 paragraph, talks about June 17.
17:42 Is it your opinion that nothing significant
17:42 with respect to this case happened between the 11th
17:42 and the 17th?
17:42 **A. Nothing that I felt necessary to include in my report**
17:42 **at this point.**
17:42 Q. You indicate that "Deputy Licavoli found Stojcevski
17:42 lying on the floor in his cell on his back, unable to
17:42 speak and blinking his eyes."
17:42 Of what relevance was the fact that
17:42 Licavoli found him unable to speak and blinking his
17:42 eyes on the floor of his cell?
17:42 **A. That's a description of his condition.**
17:42 Q. Is it relevant to this case?
17:43 **A. Well, I'm not sure what you're really asking when you**
17:43 **say, "Is it relevant to this case."**
17:43 **I mean, his medical condition, or his**
17:43 **condition at any given time, seems to be at issue**
17:43 **here. So descriptions of his -- of his condition from**
17:43 **time to time would seem to be pertinent.**
17:43 Q. Is it relevant to you that on the 17th he was unable
17:43 to speak and blinking his eyes?

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17:43 What does "unable to speak" indicate to
17:43 you?
17:43 **A. Well, it can indicate any number of things.**
17:43 Q. What are the most significant things that it might
17:43 indicate?
17:43 **A. Most significant?**
17:43 **The inability to speak can be caused by a**
17:43 **number of issues, anything from severe pharyngitis or**
17:43 **oral pathology, to neurologic pathology, to**
17:43 **intoxication, to withdrawal, to somnolence, to other**
17:43 **psychiatric conditions: schizophrenia, depression.**
17:44 Q. You indicate then that he was taken to his -- to the
17:44 medical section and then returned to his cell.
17:44 Do you know what happened when he was taken
17:44 to what you call "the medical section"?
17:44 **A. I -- I don't have the -- I don't have the specific**
17:44 **document, or I haven't flagged it or referenced it,**
17:44 **but I understand that there was some assessment, and**
17:44 **then he was returned to his cell and referred to**
17:44 **mental health.**
17:44 Q. You then indicate that he was referred to mental
17:44 health because he was hallucinating.
17:44 **A. Yes.**
17:44 Q. So on the 17th -- did that all occur on the 17th, that
17:44 he was unable to speak -- or at least reported to be

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17:44 unable to speak -- reported to be blinking his eyes
17:44 and reported to be hallucinating? Did that all occur
17:44 on the 17th?
17:44 **A. If not the 17th, then shortly thereafter.**
17:45 Q. At this point in your report is the combination of
17:45 those three things significant: being unable to speak,
17:45 blinking his eyes, and hallucinating?
17:45 **A. Well, once again, those do describe his condition, and**
17:45 **his condition is at issue in this matter.**
17:45 Q. What's the difference between -- what is
17:45 hallucinating?
17:45 **A. Hallucinating is reporting a sensory experience where**
17:45 **there is no objective stimuli.**
17:45 Q. And that's different than a delusion; is it not?
17:45 **A. A delusion is a conclusion based on faulty thinking.**
17:45 Q. And at this point he was hallucinating.
17:45 Do you recall what his hallucination was?
17:45 **A. No.**
17:45 Q. Would it refresh your memory if I indicated, generally
17:45 speaking, that he felt that he had -- half of his
17:45 heart had been eaten, and that -- well, let's just
17:45 start there.
17:45 **A. I think it was half of his body was eaten, or**
17:45 **something like that.**
17:45 Q. And that that all happened while he was at the jail?

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17:45 A. **Yes.**
17:45 Q. Does that particular kind of hallucination fit into any particular psychiatric category?
17:46 A. **It can fit into a number of different psychiatric conditions.**
17:46 Q. The next sentence, which is at the top of page 3 indicates that "He was placed in a mental health cell, on suicide watch, under 24-hour video coverage."
Did you read anything in his medical report, or any of the medical notes, documents, or the mental health notes or documents of any kind, that indicated that he was suicidal?
17:46 A. **Well, he was -- I think he was described as suicidal. I think your question may mean was there any objective basis for that, and I don't recall reading anything that described anything that he said that would lead to that inference, other than a general concern that his -- that his behavior might put him at risk for some self-harm. But I don't recall any verbalizations of suicidal intent.**
17:47 Q. Do you know -- do you have an opinion, or do you know based upon your experience, as to what a suicide watch is?
17:47 A. **Well, I have some understanding of what suicide watch is based on my experience, and that would be close**

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17:47 **observation; that would be environmental safety, so removing the means for self-harm, no sharps, paper clothing, finger foods, no utensils. Measures of that -- of that sort to reduce the risk of self-harm.**
17:47 Q. Would it also include lack or reduced ability to go out and socialize with other members of the jail community?
17:47 A. **Well, that's not necessarily part of suicide watch in itself, but in some instances it may be. And what you're talking about is increased degree of confinement. And that's not necessarily part of suicide watch. It may be in some instances or in some environments.**
17:48 Q. Might there be any negative psychiatric consequences to placing somebody in a suicidal watch cell who is not suicidal?
17:48 A. **Well, anything is possible, but if you're going to make an error, you want to err on the part of being conservative and overreact to the risk of self-harm rather than under react.**
You know, isolation in a corrections pop -- correction setting might be instituted to reduce the risk of obtaining the means for self-harm from another inmate or obtaining the means for self-harm in an area of the -- of the lockup or of a prison or of a jail

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17:48 **that's not as environmentally safe.**
17:48 Q. You indicated -- you just used the phrase "the indications of self-harm." What were the indications of self-harm?
17:48 A. **Well, I think when you asked me that previously, you asked me if I had heard anything or read anything that would lead to the mental health professional's inference that he was at risk for self-harm. And my answer was: Other than his disorganized behavior, I didn't see anything where there was anything he directly expressed that would lead to that inference. But certainly disorganized behavior increases the risk of self-harm for inadvertent reasons or for intentional reasons.**
17:49 Q. What do you mean, "disorganized behavior"?
17:49 A. **Well, if someone is confused, if someone is hallucinating, if someone is operating under a delusion, their behavior may be disorganized. They may have an impairment in their ability to take in information, process it, and act on it in a consensually validated way.**
If someone is operating under a delusion of persecution, they may take some measure to protect themselves that puts them at greater risk. They may jump out of a window, because someone's trying to

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17:50 **chase them; or they may run out into traffic, because they think they're being chased or persecuted; or they may do something unwise or something self-destructive in that instance.**
17:50 Q. And is that justification, in your opinion, that something -- that somebody may do something like that, even though they have expressed zero intent to do something, they have not shared an idea to do something like that, they have not identified a plan to commit suicide, is it your testimony that somebody who hasn't done any of those things is appropriate for placement in a high-observation suicide that -- a suicide cell?
17:50 A. **Well, surely you don't mean that everyone who intends to harm themselves is going to express that intent or is going to disclose that intent. Although many people do, many people who do complete suicide do not disclose their intent. So mental health professionals have to make inferences based on other aspects and other observations.**
But suicide watch may be instituted when -- when an individual's behavior is disorganized, and that increases the risk of self-harm whether it's by intent or whether it's inadvertent.
17:51 Q. Your statement that not everybody who's going to

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commit suicide expresses an intent to do so, I certainly would agree with you.

A. Well, thank you.

Q. The other side of that coin is that: Just because somebody acts in a -- what you phrase disorganized fashion ought to be placed in a suicide cell; is that true as well?

A. Well, no. I think -- what do they call that? A hyperbole. I say something, then you raise it to a level of absurdity and ask if that's what I said, and that's not what I said, or that's not what I meant.

But disorganized behavior may be one of the reasons that you would place someone on a suicide watch. Because a suicide -- look, penicillin is used to treat syphilis. We don't call it an antisyphilitic.

Suicide watch implies close observation and environmental safety. And there may be a number of reasons that you want to put someone in that environment; not only because they have suicidal intent, but again, because there's something about their behavior, or something about their expressions, that the clinician feels raises the possibility of self-harm, whether by intent or whether it's inadvertent.

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Q. So other than what you've called disorganized behavior, did you see any other indication of suicidal intent or behavior?

A. Well, if someone says that their body has been destroyed, they're talking about self-destructive ideas; and in certain instances, that might be an indication of intent to self-harm.

If someone talks about being persecuted -- and he didn't talk about being persecuted directly -- but that may be the projection of suicidal ideation out on an environment. So there are a number of different reasons.

In this instance I -- by my recollection, the disorganized behavior I believe led to the inference that he needed to be in a -- in a suicide watch environment.

Q. Didn't you already include the fact that -- of his hallucinatory behavior in the disorganized behavior? Isn't that part of a disorganized behavior?

A. Well, not everyone who's disorganized hallucinates, and not --

Q. I didn't say that.

A. -- everyone who hallucinates is disorganized, so I think that they're separate. So I think I already included that in what I said, and when I reiterate it, I wanted to make sure I was being thorough.

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Q. Was his hallucinatory behavior part of his disorganized behavior?

A. No, I'd say those are two different things.

Q. Two different things.

What was his disorganized behavior then? What did that consist of?

A. I think I already answered that when you asked me to define disorganized behavior, and I gave the example that -- or I gave the definition --

Q. What was his?

A. Wait. Can I finish?

Q. Yes.

A. Thank you.

-- that disorganized behavior can be an impairment in the ability to take in information, process it, and act on it in an appropriate manner or consensually validated manner. And hiding under the bed, blinking his eyes, not speaking, and then stating that his body had been damaged in the jail, those are all manifestations of disorganized behavior.

Q. So then based upon what you just told me, thinking that his body was half eaten, I just asked you if that was part of his disorganized behavior, you said, "No, that was separate." Now you've listed it as part of his disorganized behavior. Which one is it?

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A. I said it was -- well, now, you can just argue with me, if you like. I'm trying not to be difficult, but when -- you talked about hallucinations as being part of disorganized behavior, and then I said, Not everyone who hallucinates is disorganized, and not everyone who is disorganized hallucinates, that those are two different phenomena.

But certainly offering a recollection of something and stating something had happened to him that was, A, unlikely and not consistent with reality, and B, something that was not likely to have happened in the past or misremembering the past, that implies a level of disorganization as well.

Now, I can talk about this a lot, and psychiatrists do address these kinds of issues. If this is what we need to discuss, I'm happy to spend the time doing it.

Q. Dr. Shiener, I'm going to ask you what we need to discuss. You don't need to worry about that.

So is --

A. I'm not worried in the least, Mr. Ihrie.

Q. All right. So what was his disorganized behavior absent the hallucinations?

A. Everything else I said about it a few moments ago, the

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first time you asked me.
Q. You told me --
A. We're not going to argue about what I told you. You can read from the record, if you want.
Q. I understand that you told me what disorganized behavior is, but I'm asking if it related to him, to David.
A. I believe I did --
Q. You did not.
What was his disorganized behavior?
A. I don't want to argue with you, but I did. And I --
Q. Forgive me then for not --
A. I -- well --
Q. -- for not hearing that.
A. There's nothing to forgive you for. I don't hold it against you.
Q. What was it?
A. Hiding under the bed, not speaking, blinking his eyes. And by that description there is some inference that he was disturbed, because there was no reason for him to hide under the bed.
Q. I didn't see where he was hiding under the bed. Where did you see that?
A. Oh, excuse me. On the floor of his cell. Excuse me. On his back, unable to speak, and blinking his eyes.

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Q. So lying on the floor, being unable to speak, and blinking his eyes, those are the -- what you would categorize as the disorganized behavior for David?
A. Those are representations of disorganized behavior.
Q. Were there any others with respect to David?
A. Not in the descriptions that I have in my report. There may have been more rich descriptions in the record.
Q. You next say, "He was seen by a physician."
I'm trying to understand the chronology of your report. Is your testimony that he was placed in a suicide watch cell, and then he was seen by a physician?
Strike that question.
Is there a chronology to your report?
A. I tried to put things in chronological order as best as I could reproduce them from the record.
Q. And so if we see that you say, This happened, and then this happened in the next sentence, may we presume that it is your opinion that those happened in chronological order?
A. I tried my best to do so.
Q. Thank you.
So after he was put in the 24-hour suicide watch cell, you indicate that he was seen by a

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physician.
A. Yes.
Q. What physician was that, if you know?
A. I believe it was Dr. Sherman.
Q. And what did Dr. Sherman -- do you know when that was, when he saw him?
A. Not without looking at the record. I referenced it; I didn't put a date on it. So I don't know how long after his being placed on suicide watch the evaluation took place or the assessment took place.
Q. Do you know if he saw him on -- what day was he placed in suicide watch; do you know?
Licavoli, you identified in your report, indicated that on June 17, 2014, that's when Licavoli found him.
A. I think you already asked me that, and I think I said it was either on the 17th or shortly thereafter. I don't know which day -- which day.
Q. Well, I didn't ask you about the physician, because we just got to that. So do you know --
A. You didn't -- the question you just asked me had nothing to do with a physician, so...
Q. I understand. I went back to Licavoli.
When did Dr. Sherman see him? Was it the 17th or the 18th? Is that what you're saying?

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A. No, that's not what I'm saying.
Q. Well, my question is: When did he see him?
THE WITNESS: Would you go back to the first time he asked me that and read my answer, please?
COURT REPORTER: The first time Dr. Sherman saw him?
THE WITNESS: No, the first time I was asked about Dr. Sherman. Go back to the very first time.
(The following portion of the record was read by the reporter at 5:59 p.m.:
Question: "Thank you.
"So after he was put in the 24-hour suicide watch cell, you indicate that he was seen by a physician.
Answer: "Yes.
Question: "What physician was that, if you know?
Answer: "I believe it was Dr. Sherman.")
COURT REPORTER: Is that what you wanted?
THE WITNESS: No, keep going.
(The following portion of the record was read by the reporter at 5:59 p.m.:
Question: "And what did Dr. Sherman -- do

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you know when that was when he saw him?
Answer: "Not without looking at the record. I referenced it; I didn't put a date on it. So I don't know how long after his being placed on suicide watch the evaluation took place or the assessment took place.")
BY MR. IHRIE:
Q. So now my question is: Will you look at your record and tell me -- your materials and tell me when Dr. Sherman saw him?
A. Might take me a moment to find it.
Q. I understand.
MR. CHAPMAN: If it's helpful, Doctor, you can look at Sherman's deposition through the index.
THE WITNESS: I'm looking at the mental health records on this. Let's see.
What's the name of the app, the deposition app?
MR. CHAPMAN: What?
THE WITNESS: What's the name of the deposition app? E-trans? No. What's the name of the app to read the deposition files? It's a PTX.
MR. CHAPMAN: An E-trans? I'm not sure.
THE WITNESS: Okay. Deposition Reader. I

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don't have this on the new computer.
MR. IHRIE: Bob Gazall, can you hear us?
MR. EADS: Yes, I can.
MR. IHRIE: All right. Just so you know, Dr. Shiener is just reviewing some materials right now, so -- in case you're wondering if we all hung up on you.
MR. GAZALL: Yeah, no. That's fine.
THE WITNESS: You can only hope.
MR. IHRIE: Said he's what?
MR. CHAPMAN: Said he can only hope.
(Recess taken at 6:06 p.m.)
(Back on the record at 6:12 p.m.)
THE WITNESS: Now, your question was?
BY MR. IHRIE:
Q. You wanted her to read it back, I think.
A. You can just tell me.
Q. Okay. When did Dr. Sherman see him?
A. Looks like Dr. Sherman said that he saw him in medical on the 17th, from his deposition, which would be page 119.
Q. All right. Is the chronology of what happened in this case important?
A. In some respects it is, yes.
Q. In what respects --

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A. Well --
Q. -- is it?
A. -- it's when there are changes in the patient's clinical condition, and then when the assessments were made based on the changes, and whether there were any changes in the treatment program based on the changes in his condition.
Q. So your testimony is that Dr. Sherman saw David after David was unable to speak, blinking his eyes, and hallucinating, and after he had been put into the suicide cell; is that correct?
A. Well, let's see. What does he say? Excuse me.
Page 121, "All right. Do you see under the body of the note where it says, Late entry for 6-17-14, at 7:15 a.m., staff responded to a call in mental health, patient was noted lying and twitching his eyes."
Q. What is it that you're reading, Doctor?
A. This is Dr. Sherman's deposition.
Q. Do you know what document Dr. Sherman is referring to in that?
A. (No verbal response.)
Q. Well, let me just back up.
A. He said -- this says: "Well, he was brought over to you in the morning; was he not?

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"No, this was afternoon.
And then you said -- you read from Deposition Exhibit Number 3 marked for identification, and it's called the Sherman 3 note.
"And do you see under the body of the note where it says, Late entry for 6-17 at 7:15 a.m.?".
Q. I think my question, Dr. Sherman, might be a little simpler than that.
A. I'm Dr. Shiener.
Q. I'm sorry. I apologize.
A. That's even simpler, because I'm here, and he's not.
Q. You indicated that he was seen by a physician in your report.
A. Yes.
Q. On the 17th.
A. Yes.
Q. And you indicated previously that you do your best to write things in chronological order.
A. Yes.
Q. So did he see -- did Dr. Sherman see him after the patient was unable to speak, blinking his eyes, and hallucinating, and after having been put into the suicide cell?
A. No, apparently not after being put into the suicide cell.

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Q. So --
A. He saw him in the medical unit or in his cell near the medical unit.
Q. And you now know that.
A. Well, that's what Dr. Sherman said.
Q. So your chronology, at least to the extent that you've gone to the second line on page 3, has -- is not accurate, correct? Is that what your testimony is?
A. Well, it's accurate that he was seen by a physician. It's just not accurate that he was placed under -- that's it's after where he was placed on a suicide watch. It should be: He was seen by a physician, and then he -- after he saw Dr. Sherman, he was put in a mental health cell on a suicide watch.
Q. All right. So the chronology as you have it is not correct, though, correct?
A. Well, what I said was I did my best to put things in chronological order. And I would have been better -- I think we would have all been better served if I had placed that second sentence before the first sentence.
Q. Your next sentence says, "He was described as talking to himself and eating very little."
And that's a period after the word little; is that correct?
A. Yes. That's right.

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Q. And he was described by whom?
A. I don't recall.
Q. And when was he so described?
A. I believe that was while he was in the -- at some time while he was in the mental health cell.
Q. Some time -- well, he was in the mental health cell for ten days.
A. Yes.
Q. So your testimony is that "Some time while he was in the mental health cell."
A. That's right.
Q. Sometime during those ten days he was described as talking to himself and eating very little.
A. Well, I think not only is that in my report, but I already answered "yes" when you asked me that before.
Q. And is this chronologically accurate as well?
A. I believe it's in the mental health -- while he was in the mental health ward; I just don't know what day that that note is from.
MR. CHAPMAN: Without being pejorative, are you going to sometime get to his opinions? None of this matters. Get to his opinions.
BY MR. IHRIE:
Q. Why did you put that in your report, that he was described as talking to himself and eating very little?
A. Oh, I felt it would help to understand what happened to him, how he was acting.
Q. Is that fact important or those facts important?
A. Well, when you say "important," I'm not sure -- I'm not sure what you mean. If I wanted to put in everything that I thought was important, I'd be paraphrasing and dictating this whole set of papers and the whole set of electronic records into a report, and that would be redundant. I didn't think that was necessary.
I thought it was representative, and I'd use the term "representative" rather than "important."
Q. But you didn't dictate everything, and you chose certain facts that you observed or read about, and you put certain facts into your report and not others, correct?
A. Oh, I think I just said that, didn't I?
Q. So my question is: As background information to your ultimate conclusions, is the fact that while he was in the suicide cell he was described as talking to himself and eating very little important to your ultimate conclusion?
A. I think I already answered that.
Q. Well, if it is, I would like to know why it is. If it's not, I'd like to know why you put it in there. I'm not trying to lead you somewhere. If it's important, please tell me.
A. I don't think I can answer it the way you've asked it. I think that -- I think that what I tried to do was put some things in this document that would be representative.
Q. Of what?
A. Of the course of his stay in the jail, in different parts of the jail, and descriptions of his condition, and that if I wanted to put everything important, I would have generated an unwield -- everything that I thought was important, the document would be unwieldy.
So I just -- I put that sentence in, because I thought it was representative.
Q. And what was it representative of?
A. Of some of the things that they said about him, when he was in the mental health ward.
Q. Then you go -- you jump from the 17th or the 18th to June 25, where you indicate, "From June 25 until his death on June 27, he laid on the floor in his cell, shaking and blinking his eyes."
Now, in the course of this paragraph you've addressed that he was reported as talking to himself, eating very little, blinking his eyes, and shaking.

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Why was it important to put those representative -- to use your word -- observations into your report?
A. I didn't say it was important, I just thought that those were representative of what had happened by way of a summary.
Q. Did that have anything to do with what David was going through, or any diagnosis, any conclusion? Did it have anything to do with your conclusion?
A. Well, they're representative of some of the behaviors that led to my conclusions. I didn't end my document there; I include other information as well.
Q. I understand.
A. Well, if you do, then I don't understand your line of questioning. I'm not sure what you're really getting at or what you're trying to ask of me.
Q. Why did you want the reader of your report to know these four things: that he was observed talking to himself, eating very little, shaking, and blinking his eyes?
A. I don't think I have anything more to say about my intent in preparing this document.
Q. Looking at the next paragraph, the second sentence, you indicate -- well, let's look at the first sentence first.
You understand that you were hired by the

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attorney for Correct Care Solutions, correct?
A. I do.
Q. And Correct Care Solutions, as you indicate, was to provide psychiatric and medical care at the Macomb County Jail as a contract provider. Then you indicate that there -- your next sentence reads: "There were policies, procedures, and nursing policies describing inmates' -- describing inmates' receipt of timely health care for serious medical, dental, and mental health needs."
I don't know what that sentence means. Can you please tell me what that means?
A. I don't know that I can help you understand it. I think that describes the role of Correct Care Solutions and their agents.
Q. When you say that there were pol -- "the policies, procedures, nursing policies describing inmates' receipt of timely health care," that's -- it's the word "describing" that I'm having a problem with. I don't understand what you mean when you say the policies and procedures described inmates' receipt of timely health care.
A. I don't get how you couldn't understand that. It seems fairly straightforward.
Q. Well, which inmate or inmates did the policies,

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procedures, and nursing policies describe their receipt of timely health care?
A. People in need of services.
Q. So you want to stick with the word "describing"?
A. When you say, Stick with it, I don't know what you mean. It's already there.
Q. Okay. What did you look at or review to determine what corrections officers were trained in or not trained in? Which one of the list of documents that you reviewed on pages -- your first and second page did you look at to make that determination?
MR. CHAPMAN: Object to form and foundation.
THE WITNESS: Oh, I don't know if it was in the sheriff's re -- I don't know where it was. I must have read it somewhere in these documents.
BY MR. IHRIE:
Q. So you're really opining that somebody else said that the corrections officers were trained?
A. Well, there were investigations. I read a sheriff's investigation. Some of the corrections officers spoke about their training or spoke about what they were supposed to know how to do in their depositions. I don't recall where I gleaned that specifically.
Q. Well, you didn't look at any training materials, did

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you?
A. I don't think so.
Q. None are listed on your list of materials that you reviewed for your report, are they?
MR. CHAPMAN: What's the question?
MR. IHRIE: He knows the question. That's why he's --
THE WITNESS: Okay. It doesn't look like I had any manuals at the time that I prepared the report.
BY MR. IHRIE:
Q. How is it then that you can state objectively and with relative emphasis that "corrections officers were trained in assessing inmates' needs for nutrition and hydration"?
MR. EADS: Form. Object to form.
THE WITNESS: Well, I don't -- I don't recall where I read it. I did read a number of corrections officers' depositions.
BY MR. IHRIE:
Q. And --
A. They made reference to it in their depositions.
Q. So when you say "corrections officers were trained," are you really saying that somebody else said they were trained, or a corrections officer said they

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individually were trained? Is that what you --
A. Well, that may have been the base -- that may have been the basis for that statement.
Q. You understand that saying that somebody said they were trained, or told you that they were trained, is different than your conclusion that they indeed were trained. Those are two separate things; are they not?
A. Well, if they say so under oath, they say that they were trained under oath, I'm not sure what the difference would be.
Q. Is it your testimony that every time somebody testifies under oath, they're telling the accurate truth?
A. There you go, there's that hyperbole again. When I say something, you restate it in a way --
Q. Just what's the answer to my question?
A. Well, that's the answer to my question. The answer to my question is what I said, not the hyperbolic rephrasing or paraphrase of what I said. So -- and I've already told you that I like the way I say things better, and if you're going to paraphrase and ask me if that's what I said, my answer is going to have to be: No.
Q. I didn't ask you that. My question is very simple. Is it your testimony that everybody who testifies

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under oath is telling the accurate truth?
A. I didn't recall saying that.
Q. I ask -- I didn't say that you did say it, sir. I'm asking you if that is your opinion.
A. No, that's not what you asked me. You asked me if it was my testimony.
Q. No, I didn't.
MR. CHAPMAN: You did.
THE WITNESS: Read from the record. Now --
BY MR. IHRIE:
Q. All right, that's --
A. You can -- I'm going to cooperate with you.
Q. That's fine.
A. But -- but I'm not going to engage in this. And you're not going to ask me the question three times and then change it.
Q. I'm asking you: Is it your opinion --
A. Well, which question do you want me to answer?
Q. Is it your opinion that everybody who testifies under oath is telling the accurate truth?
A. Well, that seems pretty absolute. It would be hard to hold onto that kind of opinion.
Q. So when you say that you read, and they were under oath when they testified that they had been trained, is that good enough for you to --

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MR. CHAPMAN: Objection, that's --
BY MR. IHRIE:
Q. -- make the statement --
MR. CHAPMAN: That's not what he testified to.
BY MR. IHRIE:
Q. Let's just identify the fact that -- and agree with me, if you will, that anything you know about whether officers were trained came from either a deposition where somebody else was saying they were trained, or somebody else was making a statement about training --
A. Or maybe something I read in some other case.
Q. Let me finish my sentence.
You didn't investigate the training yourself, did you?
A. I didn't conduct my own police investigation of what was said in any of these records. I didn't go out and ask these guys if they were telling the truth during their deposition. I didn't go out to the jail and say, "Well, this is what's supposed to happen; is this what really happens." I don't think that's what my job was here.
Q. You put down in your report that you read Deputy Harrison's deposition, correct?
A. I did.

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Q. Do you recall reading in his deposition where he specifically indicated that he was not trained to monitor food and water intake at the jail?
A. I haven't committed his deposition to memory.
Q. Well, if he did say that in his deposition, and for the sake of this question I want you to presume that he did, why would you say in your report that deputy corrections officers were trained?
A. Well, just because he --
MR. EADS: Let me just object to form. That's two completely different issues. His report is different from the question you just asked, so I'll just object to the form and hypothetical.
MR. CHAPMAN: I'll join.
BY MR. IHRIE:
Q. Do you know what deputy -- what corrections officers were trained to do with respect to assessing an inmate's need for nutrition and hydration?
A. I don't understand what you're asking.
Q. Well, you said they were trained --
A. They were trained to do.
Q. To do what?
A. To assess inmates' needs for nutrition and hydration.
MR. CHAPMAN: The doctor is not here to testify as to what corrections officers --

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MR. IHRIE: I know what he's here for.
MR. CHAPMAN: -- did or didn't do.
MR. IHRIE: I know what he's here for. If there's an objection, make it.
MR. CHAPMAN: Well, there is. Why are we going through this exercise of questioning him on things that's not what he's retained for? He's not giving any opinions on corrections officers, what they did or didn't do.
BY MR. IHRIE:
Q. You indicated next that "A hunger strike policy was in place."
Did you read the hunger strike policy?
A. I don't recall if I did or not.
Q. That being the case, you're not able to testify about it today then, correct?
A. About what's in it?
Q. Yes.
A. No.
Q. When you see a patient that you haven't seen for a few years, do you go back and look at his previous records?
A. If they're available.
Q. If they're available? Why do you do that?
A. To help me in my assessment.

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Q. In the next paragraph you indicate, in the second sentence, "Medical records -- "medical record." I don't know if you mean that plural, but medical -- I'll read it the way it is. "Medical record generated in 2006 would have reflected that he was taking both Xanax and Klonopin, benzodiazepine tranquilizers."
Why did you put that in your report?
A. Same reason.
Q. Well, the reason you gave me before was that it was representative of something. That doesn't seem to be logical to put that in there because it's representative of something, so my question is: Why did you put it in there?
A. Well, your opinion's noted, but that's why I put it in.
Q. Well, tell me what the answer is as to why you put it in?
A. It's representative.
Q. It's representative. Of what?
A. His medical history.
Q. Are you saying that the 2006, 2008, and 2009 records were representative of his medical history?
A. Yeah. Prior medical records would have been representative of his medical history.
Q. Well, they would have been more than representative; they would have been his medical history at the jail, correct?
A. Well, I mean, if they were accurate, and depending on the quality of the record and their completeness.
Q. So is there a reason why you put that in the report?
A. Yeah, because it was representative of his history.
Q. And it is your statement that those records, at least in 2006, would have reflected, had they been looked at, that he was taking both Xanax and Klonopin back well before he was housed in 2014, correct?
A. Say that again?
THE WITNESS: Or read it. Why don't you read it.
(The following portion of the record was read by the reporter at 6:34 p.m.:
Question: "And it is your statement that those records, at least in 2006, would have reflected, had they been looked at, that he was taking both Xanax and Klonopin back well before he was housed in 2014, correct?".)
MR. CHAPMAN: Object to form and foundation.
THE WITNESS: Well, I think that's what that says. I think that's what that sentence says,

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yeah.
BY MR. IHRIE:
Q. So I'm right when I said that, correct?
A. I'm not here to say whether you're right or wrong. That's just what it says there.
You don't want to get into my opinions on that, do you?
Q. Your last sentence of that paragraph indicates, "Michigan Automated Prescription System revealed that Mr. Stojcevski had regularly filled prescriptions for methadone, oxycodone, clonazepam, and alprazolam between February and June 2014."
Do you have any familiarity with the Michigan Automated Prescription System?
A. I do.
Q. And tell me what that is.
A. It's a system that keeps track of controlled substance prescriptions that are filled in the state of Michigan and in some other states, and if you're a mental -- if you're a health practitioner caring for a patient, you want to know his history of opiates and sedative use, analgesic use, and some other drugs that are under those schedule, you can go to a website, enter the patient's name and birth date, and attest to the reasons for which you're reviewing the record, and

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you'll get a record of prescriptions filled.
Q. Are you a subscriber to that service?
A. I don't think you have to be a subscriber. I think any practitioner can access it.
Q. Is there a fee, if you know?
A. There's no fee.
Q. Do you ever access it?
A. I do.
Q. Why?
A. Well, now it's required. Before --
Q. "Now" starting when?
A. Starting on June 1, actually. But it --
Q. This year.
A. This year.
But in the hospital we often see patients who are incapable of providing a history to us, they appear to be intoxicated or withdrawing, and so we'll look at their history, to see if there's any record of their use.
Q. Do you recall when in your practice you began to use that service?
A. Long time ago. When it was first offered.
Q. What do you have to do? Plug in your -- do you have a -- like lawyers have P numbers, you have a physician number, correct?

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A. You know, it's been so long since I registered, I don't know what you had to prove. I think it's just -- you just have to have a license number. I don't think you need a DEA or anything. But if you have a license number, and you're a registered practitioner, and you're in good standing with the state, then you can access the database.
Q. Have you ever had patients that you thought were drug seeking from you?
A. Well, I mean, any --
Q. Inappropriately drug seeking?
A. Sure.
Q. How long does it take to -- for you to log into the MAPS system and learn what you wish to learn?
A. Now it's quite quick. Before maybe the last -- I think within the last 12 to 18 months, the system's been changed. Before it was changed it was a little more lengthy, you know, to -- it could be about a 20-, 25-minute endeavor.
Q. And if you do log in, you can learn what prescriptions have been prescribed to a certain patient, correct?
A. No.
Q. What can you learn?
A. What prescriptions have been filled.
Q. Have been filled.

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A. And reported.
Q. All right.
A. And --
Q. And how often --
A. Yeah.
Q. -- they've been filled, correct?
A. I think under the old system you could choose how -- I don't know if you could chose how far back you went or if there was a limit of -- but now the limit is about 18 months, and you get a list of prescriptions that have been filled. You know, the accuracy is sometimes questionable, but it's better than not having any information.
Q. If the accuracy is sometimes questionable, why have you used it? You said you've used it for years.
A. Well, I've -- because some information is better than none. And it doesn't tell you about diversion, it doesn't tell you -- first of all, if a patient has a lot of prescriptions, it doesn't tell you if they're using the drug or selling it. And if a patient is buying it from someone who's diverting it, it's not on the MAPS. But it's informative.
Q. And you indicated that -- on your third paragraph on page 3, that "Michigan Automated Prescription System revealed."

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How was it that you saw the Michigan Automated Prescription System with respect to Mr. Stojcevski?
A. If I didn't see the report -- I think number 5 on page 2, Michigan Automated Prescription System. So I did have a report.
Q. I understand that; but where did you -- did you -- where did you get that? Did you look it up yourself?
A. No. No, it was provided to me.
Q. That was provided to you.
MR. CHAPMAN: I got it from you.
MR. IHRIE: And we got it from the medical examiner.
MR. PERAKIS: He got it from them.
THE WITNESS: I wouldn't have been able to get it, because it only goes back a certain time period. This would have been prior to the time period that was recorded.
BY MR. IHRIE:
Q. Yeah, okay.
When Dr. Sherman saw David Stojcevski, did you see anything in the medical records that indicated that he did any kind of a physical exam on him?
A. I don't. I don't recall, but I don't believe so.
Q. Did you see anything in the records that would

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indicate that he did a neurological exam on him?
A. I don't recall.
Q. If he did, it's not in your report, correct?
A. I didn't quote his -- his notes. I believe there were only those two notes.
Q. And as you sit here today, you have no recollection of seeing anything in the records that he did, correct?
A. Nothing about a neurologic exam.
Q. Do you remember what his diagnosis -- strike that.
Do you remember what he concluded?
A. When he said he was feigning a seizure and returned him to his unit? Is that what you're referring to?
Q. Yes.
A. Yeah.
Q. Did you ever see anything in the records that indicated that Dr. Sherman after that ever did anything to rule in or rule out his opinion of feigning seizures?
A. I'm not sure what that would be, but I don't recall seeing anything to that effect, other than waiting and seeing if the condition progressed.
Q. Do you recall seeing in Dr. Sherman's deposition where he indicated that he was going to follow up with David Stojcevski?
A. I haven't memorized that document. If you want to

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refer me to a page, I'll take a look at it.
Q. Blood pressure of 150 over 98, how would you characterize that?
A. Elevated.
Q. You indicate in your next paragraph that "by June 20, '14, his behavior was described as bizarre."
Do you recall who described his behavior as bizarre?
A. No.
Q. When you say "By June 20, 2014," do you mean on June 20, 2014?
A. Yes.
Q. You next indicate that "Dr. Sherman described that he was feigning a seizure, and he was returned to his unit."
A. Yes.
Q. Is that also out of chronological order?
A. I don't -- I think the only day that could have been would have been the -- I believe Dr. Sherman said that his only notes were on the 17th. And on the -- 6-17 there was a late entry, and then the next note was 6-24.
Q. The next note of whom?
A. Dr. Sherman.
Q. And what does that June 24 note say?

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MR. CHAPMAN: When you get to a point, can we take a break for a second?
MR. IHRIE: Sure. Any time you want.
MR. CHAPMAN: Well, I don't want to interrupt your flow. If you want to go now, that's fine.
MR. IHRIE: Well, just -- the doctor is obviously looking for something, and the question on the floor is --
COURT REPORTER: Do you want me to read?
MR. CHAPMAN: Yes.
MR. IHRIE: -- is: What did he say on the 24th.
(The following portion of the record was read by the reporter at 6:45 p.m.:
Question: "And what does that June 24 note say?".)
MR. IHRIE: Yeah, what did the June 24 note say.
We'll wait until we finish the June 24 note.
MR. IHRIE: Will you mark this as Shiener Deposition Exhibit 2?
MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 2

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6:48 p.m.
MR. EADS: What's that, Bob?
MR. IHRIE: Shiener Deposition Exhibit 2.
MR. EADS: What is it, though? Sorry.
MR. IHRIE: Oh, it's Sherman's progress note.
MR. EADS: Is that the 6-24 note?
MR. CHAPMAN: No, this is the delayed entry note.
MR. EADS: Seventeen?
MR. CHAPMAN: It's dated 6-24-14.
MR. IHRIE: We'll let him decide what it is. All right?
MR. CHAPMAN: Well, that's what it is. He asked me what it is.
MR. IHRIE: Well, I'm not asking you what it is; I'm asking him what it is.
MR. CHAPMAN: I was just responding --
BY MR. IHRIE:
Q. Is this the note you're talking about?
MR. CHAPMAN: -- to John's question.
MR. EADS: He's looking at Exhibit 2?
MR. IHRIE: Yes, he is.
MR. EADS: Okay.
THE WITNESS: This note is late entry

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6-23-2014. But the deposition references a 6-24 note.
BY MR. IHRIE:
Q. Is it your opinion -- what is your opinion as to when Dr. Sherman saw David?
MR. CHAPMAN: Asked and answered. He told you the 17th a long time ago.
BY MR. IHRIE:
Q. That's one of them.
A. Seventeenth, and then there's this late entry entered on 6-24 at 7:29 p.m. that's a late entry for 6-23.
Q. Do you have an opinion as to how many times Dr. Sherman saw David?
A. No, I haven't committed the whole record to memory.
Q. Well, you read his -- you read all of the notes, and you read his deposition, correct?
A. Like I said, I didn't commit it to memory.
Q. I didn't ask you if you committed it to memory.
A. I read them.
Q. Let me ask this: Is it important how many times Dr. Sherman saw David?
A. It's more important what he said.
Q. What who said?
A. Dr. Sherman.
Q. What he said when?
A. In the later stages of Mr. Stojcevski's confinement.

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Q. Tell me what he said then.
A. Well, here he said that it was his assessment that this was a feigned seizure behavior, and returned him to the general population without seizure precautions.
Q. And is that -- did he return him to the general population after concluding that he was feigning seizures on the 24th?
MR. CHAPMAN: Objection. It's not a memory test.
MR. IHRIE: Hold. No, it's not a memory test. He's an expert witness. He's reviewed all the documents. I'm asking his opinion and what it's based upon, so --
THE WITNESS: Well, what's the question?
MR. IHRIE: The question is -- I just asked it to you.
Go ahead, read it back.
THE WITNESS: I know you just asked it. That's why I wanted you to repeat it.
MR. IHRIE: Go ahead, read it back.
THE WITNESS: But you can read it back.
(The following portion of the record was read by the reporter at 6:51 p.m.:
Question: "And is that -- did he return him to the general population after

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concluding that he was feigning seizures on the 24th?".)
THE WITNESS: Well, this conclusion appears to be on the 23rd.
BY MR. IHRIE:
Q. Then did he return him to the general population after concluding on the 23rd that he was feigning seizures?
A. That was his recommendation.
Q. Now please answer my question. Was his -- I'll ask it --
A. To be accurate, I'll have to find the record.
Q. What record is it that you're looking for?
A. (No verbal response.)
Q. Dr. Shiener?
A. I'm looking for the chronology of what happened on the 24th.
Q. We can't look -- all right. Okay. Go ahead.
A. Okay. There is a memo to jail command, then the location MHOI, "Patient is appropriate for placement on high-observation status."
So looks like he was maintained on the 24th in the high-observation status, as he was on the 25th. So he wasn't returned to the general population.
Q. Is it your opinion that Dr. Sherman on the 24th wrote a note that he had seen David on the 23rd, and made a

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recommendation that he be returned to the general population?
A. That's not an opinion; that's a description of what's listed on the Shiener Exhibit 2.
Q. So that's not an opinion, that's just the fact; is that your testimony?
A. Well, it's what the document says.
Q. And did you review that document --
A. I did.
Q. -- prior to writing your report?
A. I did.
Q. Did you factor it in?
A. Well, I considered it after I read it.
Q. So how many times, in your opinion, did Dr. Sherman see David, as far as you know?
A. I know as we're discussing this, I know of two encounters, the 23rd and the 17th.
Q. Do you feel it was appropriate for Dr. Sherman to see David on the 23rd?
MR. CHAPMAN: Object to form and foundation.
THE WITNESS: Appropriate?
BY MR. IHRIE:
Q. That it was --
A. Well, it's appropriate for a doctor to examine the

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patient. And he made -- and he apparently made an assessment.

MR. CHAPMAN: Can we take that break?

MR. IHRIE: Sure.

(Off the record at 6:54 p.m.)

(Whereupon Mr. Perakis left the room.)

(Back on the record at 7:00 p.m.)

BY MR. IHRIE:

Q. Are you ready, Doctor?

A. I'm ready.

Q. And do you remember the last question?

A. No.

MR. IHRIE: Go ahead and read it again.

THE WITNESS: Do you?

(The following portion of the record was read by the reporter at 7:00 p.m.:

Question: "That it was --

Answer: "Well, it's appropriate for a doctor to examine the patient. And he made -- and he apparently made an assessment.")

COURT REPORTER: Do you want more than that?

MR. IHRIE: No, that's fine.

BY MR. IHRIE:

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Q. Do you have an opinion as to why Dr. Sherman recommended returning him back to the general population, and he was put back into medical -- I mean, to the mental health cell?

A. I believe Dr. Sherman's assessment was confined to the likelihood that he was having a seizure or paroxysmal event and the need for close observation. It looks like it was appropriate for placement on high-observation for suicidal behavior or verbalizations, and I think that would refer back to some of the other reasons, for risk of self-harm that we discussed about an hour and a half ago.

So it may not have been -- it may have been more for psychiatric reasons than medical reasons.

Q. Did you read Dr. Sherman's deposition?

A. I did.

Q. Do you recall all those pages that talked about Dr. Sherman -- when he professed embarrassment that he hadn't written a note on the 17th, instead wrote it on the 24th, and then mistakenly put that he had seen the patient on the 23rd, when in fact he had not seen the patient on the 23rd --

A. On review --

Q. -- and in fact, had only seen him on the 17th?

A. On review during the break, I did notice that in his

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deposition.

Q. But you didn't notice that before you wrote your report, correct?

A. I didn't recall it.

Q. Is this another part of your report where the chronology is inaccurate?

A. Well, the notations were placed based on the dates of the -- of the papers. The depositions revealed something a little bit different. And I note that there was some -- apparently there's some confusion in how the computer posts the note, or when the notes are posted and when they're written and the actual encounter to which they refer.

Q. Why, if you read that in the -- Dr. Sherman's report, did you nevertheless put in your report -- strike that.

Why, if you read that in Dr. Sherman's deposition, did you nevertheless still put it in your report that he saw him on the 23rd?

A. Well, I was -- as I was preparing my report, I was reviewing those documents, so I must have -- I must have seen that in Dr. Sherman's deposition sometime after the report was prepared. I must have recalled that after the report was prepared.

And I only reviewed it during the -- during

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the break and when I was looking at that portion of the discussion starting on page 121 or 122.

Q. So is that portion of your report factually inaccurate?

A. It's accurate in the way it refers to the documentation. The documentation is mis -- is misleading and --

Q. The documentation is misleading?

A. Well, yeah. There's a note on the 24th that says, "Backdated to the late entry on the 23rd."

Q. But doesn't his deposition explain that?

A. But his deposition does.

Q. And if his deposition explained that, why did you nevertheless put it in your report that he saw him on the 23rd?

A. I must have reviewed the deposition afterwards or later.

Q. So your testimony now is that: Some of the matters that you said in your report that you reviewed prior to writing your report, actually you didn't review them prior to writing your report; at least this one you are testifying that you reviewed after you wrote the report, correct?

MR. CHAPMAN: Objection: argumentative.

THE WITNESS: No, that's not what I said.

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What I said was that I report -- I recorded the documentation in my report, and the documentation was misleading. The documentation was inaccurate, and it was only after I later reviewed Dr. Sherman's deposition about his embarrassment and the reasons for late entry that I realized that that was a -- the date on that, the June 24/June 23 entry, was inaccurate.

BY MR. IHRIE:

Q. Why didn't you amend your report then?

A. I neglected to do so. I don't recall as to why.

I did understand that I'd have an opportunity to discuss it in person.

Q. Pardon me?

A. I did understand that I'd have an opportunity to discuss it in person.

Q. What is decompensation?

A. Well, decompensation is a term that's commonly used in psychiatry to refer to the emergence of symptoms of a psychiatric illness that has an intermittent or episodic presentation, or of the failure of an individual's coping abilities to deal with a stressor which -- with which they're presented.

Q. So how would you interpret -- I'm looking at the last the last full paragraph, Doctor, on page 3.

So how would you interpret Nurse Brock's

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note that you reference, where it says, "He was described as being" -- I'm sorry.

"A self-harm watch initial assessment was undertaken by Mental Health Provider Brock on June 18, 24 (sic). He was described as being in need of assessment for decompensation?"

How would you interpret that statement?

A. The -- well, that is an example of a mental health professional using the term -- a jargon term, in maybe not the most precise manner. But what I infer from that entry, decompensation meant the emergence of disorganized behavior or behavior that was not understandable to her that needed to be assessed.

Q. Your next line says, "Nurse Cueny noted on June 24, 2014, that Mr. Stojcevski did take Klonopin, two to three tabs at home, and the last time it was taken was two weeks ago."

Do you see that sentence?

A. Yes.

Q. So when did Ms. Cueny see -- Nurse Cueny see David?

A. Once again that was an inaccurate note, because after that I say, "Dr. Sherman described that he knew on June 18, or the next day, that Mr. Stojcevski had used benzodiazepines."

So Nurse Cueny, the date on the note

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appears to be the 24th, but I believe it referred to an earlier assessment that she made.

Q. Do you remember the date of the earlier assessment?

A. I can only infer that it was a week prior, that there was some calendar issue of punching the wrong date.

Q. So a week prior would have been the 17th or the 18th?

A. I believe so.

Q. Right around the day, or within hours, of David having hallucinations?

A. Well, if saying that half of his body was eaten up is a hallucination or a delusion. There's some discussion as to what that was.

But when that behavior was described, the knowledge of his use of benzodiazepines was either disclosed to Nurse Cueny, or Nurse Cueny disclosed it to Dr. Sherman.

Q. What did she disclose?

A. That he had been taking Klonopin before that.

(Whereupon Mr. Perakis returned to the room.)

BY MR. IHRIE:

Q. Do you know if the nurse he had told that he was taking Xanax ever disclosed that to Dr. Sherman?

A. I don't know. I don't recall. Dr. Sherman just said he used benzodiazepines, so I don't know if he knew

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which specific benzodiazepine.

Q. Did you read in Dr. Sherman's -- well, strike that.

Some benzodiazepines are short-acting, and some are long-acting, correct?

A. Yeah. I've had that discussion.

Q. Is that something, in your opinion that a doctor who is dealing with -- in a jail setting, by definition dealing with people who are abusing drugs, should know?

MR. CHAPMAN: Object to form and foundation.

THE WITNESS: What is it that they should know? To what are you referring?

BY MR. IHRIE:

Q. Which benzodiazepines are -- the difference between long-acting and short-acting benzos?

A. Well, I want to be careful in answering that. That is a complicated issue, and there are -- for example, the medication Xanax is considered to be shorter acting, but it has active metabolites, so it may have a slightly longer duration of action than its half life would indicate. Klonopin has a slightly longer duration of action and a slightly longer half life.

I mean, those are things that a physician who's dealing with patients who take these medicines

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should know, but 77 million prescriptions for benzodiazepine tranquilizers are written in the United States every year, and --

Q. So they're quite common.

A. Pardon?

Q. So they're quite common?

A. They are quite common.

Q. I don't know if you're aware of it, but tell me if you are. Are you aware when Sheriff -- Macomb County Executive Hackel indicated that the county jail, the Macomb County Jail -- and I may be paraphrasing here -- essentially had become repositories for those who are abusing drugs and for the mentally ill?

MR. CHAPMAN: Object to form and foundation.

THE WITNESS: Well, I know that the Wayne County Jail is the largest psychiatric facility in the state of Michigan, and I know that a significant portion of inmates in jails and prisons are mentally ill, were intoxicated at the time of their confinement, or were -- or had abused drugs, or had used prescription drugs or nonprescription drugs in the -- in the days prior to their incarceration or confinement.

BY MR. IHRIE:

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Q. Did you read in your --

A. I don't know exactly what Sheriff Hackel said, but I know that Judge Kenny in Wayne County talked about the needs of the jail and the function that the jail has come to serve in this era versus the era where asylums were more available.

Q. I believe it was Nurse Bertram that was advised by David --

MR. IHRIE: Tell me if I'm wrong on this, Harold.

BY MR. IHRIE:

Q. But I believe it was Nurse Bertram that was advised by David on the 17th that he had been taking Xanax?

As a mental health worker, do you think she should have told the -- either the director of nursing or the director of -- medical director, Dr. Sherman?

MR. CHAPMAN: Object to form and foundation. He's not here and an expert as to what a nurse should or shouldn't do.

MR. IHRIE: Well, you may not have him here as an expert for that, but he's already told me he's an expert on things that I feel fall under the umbrella.

I think it was Bertram.

MR. CHAPMAN: I have no idea what you just said, but he's not here as a nursing expert, so he's not giving testimony as a nursing expert.

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THE WITNESS: Well, that's really not particularly pertinent to my opinion, but history -- it's traditional for history to be recorded somewhere in the medical record.

BY MR. IHRIE:

Q. And if I told you -- well, tell me why it's recorded -- why history is recorded in a medical record.

A. Because a medical record communicates the patient's condition among the multiple professionals caring for a patient.

Q. So if I have contact with a patient, should I put what -- you know, the essential elements of my contact with that patient in a medical note?

A. With all due respect, no. I don't think a lawyer's contact with a patient has any place in a medical record.

But if your question is if you were a nurse or a doctor --?

Q. Yes.

A. I think it would -- tradition suggests that you should communicate your findings in some way.

Q. And is that tradition -- does that tradition exist to communicate findings for a medical -- a valid medical reason that will be of help to a patient?

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MR. CHAPMAN: Object to form and foundation.

THE WITNESS: Well, again, in any setting. Communication between you and Mr. Perakis would be important, because you're both working on this matter, and you should keep each other aware of what you're doing, so your efforts can be coordinated, so your efforts are not duplicated, or so you're not working at cross-purposes. And in general people taking care of a patient should communicate their -- their concerns or their impressions or their observations, in general.

MR. IHRIE: Okay. It was Bertram, right? Yeah, Bertram.

BY MR. IHRIE:

Q. You put in your last note -- in your last line on that last full paragraph on page 3, starting about halfway down, "Nurse Cueny noted June 24, 2014, that Mr. Stojcevski, quote, did take Klonopin, two to three tabs at home, and the last time it was taken was two weeks ago. Dr. Sherman described that he knew on June 18, 2014, or the next date -- the next day, that Mr. Stojcevski had used benzodiazepines. He described

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that he discussed the matter with Nurse Cueny and considered the prospect of benzodiazepine withdrawal."

Did you read Nurse Cueny's dep?

A. I did.

Q. Do you recall when she said she couldn't remember whether she told Dr. Sherman about the hallucinations? Do you remember that?

A. I don't -- I haven't memorized her dep. If you want -- I mean, I have it here. If you want to direct me to a page --

Q. Well, I'm not --

A. -- I'll see what she says.

Q. My question is just: Do you remember.

If you don't --

A. I haven't memorized the document. I remember some discussion, but I don't recall the details.

Q. Looking at your last paragraph on page 3, it indicates, "Progress notes from Nelson, Mann, and Brock repeatedly describe Mr. Stojcevski as "refusing" to respond."

Why did you put the word "refusing" in quotation marks?

A. You know, I think that was the language that they used, or that was the language that I read, whatever document I'm referring to.

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Q. "And the assessment was that he was feigning for secondary gain."

A. That's right.

Q. I will show them to you, if you wish, but all -- virtually all of the mental health reports from the mental health personnel indicated -- in the vast majority of categories that they were asked to assess him for indicate "unable to assess, unable to assess, unable to assess, unable to assess, unable to assess."

Do you recall seeing that?

A. I do.

Q. In your conclusion, though, that the assessment of Nelson, Mann, Brock -- and Brock, their assessment was that he was feigning for secondary gain?

A. I believe that's -- I believe that's what I read. Unless it was Dr. Sherman's characterization of what they said or...

Q. Do you know if there was a -- if the Macomb County Jail had a psychiatrist?

A. They had a psychiatrist.

Q. If I said his name was Dr. Haq --

A. Dr. Haq.

Q. -- Haq, do you know him?

A. There are a lot of Dr. Haqs. It's a common Pakistani name.

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When you say, "had a psychiatrist," I know that someone consulted. I don't know what the nature of the relationship was or how freq -- what the availability of that doctor was.

Q. Is there an appropriate protocol -- do you have an opinion as to whether or not there's an appropriate protocol when a mental health professional is unable to assess a patient on a high suicide -- in a high suicide cell?

A. Well, that they should articulate the reason for their inability to assess.

Q. Is there any --

A. And, for example, if a patient's nonverbal, they should say they can't assess because a patient's not speaking, and then --

Q. I'm sorry; I didn't catch that.

A. If a patient is nonverbal, then they say "unable to assess," and then the reason for the inability to assess.

Q. And I didn't see the reason for the inability to assess in any of those reports, did you?

A. I haven't --

MR. CHAPMAN: I'm going to object to form and foundation. Mischaracterizes the testimony and the record.

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BY MR. IHRIE:

Q. Would it be appropriate to call a psychiatrist as a mental health professional, "Every day I go and see this person, and he's nonresponsive or unable to -- either refusing to talk"?

A. Well, now look, if he's nonresponsive, that might indicate a need for an assessment by someone with greater expertise, someone's nonresponsive. But if someone is just not verbalizing, that may not necessarily be a reason to call a psychiatrist.

Q. And how does one know the difference?

A. Well, if you're talking about a mental health professional, they have to make a clinical judgment.

Q. So at the top of page four you indicate that "His nutritional intake was poor"?

A. Yes.

Q. And what do you base that on?

A. I think that's what the records describe. There was an episode -- well, they describe that he was eating and drinking intermittently.

Q. And who described that?

A. I don't recall the specific observers.

Q. Do you recall if it was medical personnel or mental health personnel or jail personnel?

A. I believe it was mental health personnel. It may have

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been jail personnel.
Q. Then you indicate that "He was incontinent of stool"?
A. Yes.
Q. Then we have a corrections officer, you indicate Officer Perry, on the 22nd indicating he was incoherent?
A. Yes.
Q. And then you indicate that Dr. Sherman evaluated Mr. Stojcevski on the 23rd, concluding that he was feigning seizure behavior, and returned him to the general population.
That's the sentence I believe that you previously indicated was not accurate, correct?
A. It was -- it references a note that's not accurate.
Q. But when you wrote your report, Dr. Shiener, you believed that Dr. Sherman evaluated him on the 23rd, correct?
A. I think we discussed this matter already, and my answer is no different than it was the last time we discussed it.
Q. Well, you're giving a little different answer, so I want to clarify.
When you wrote your report, you believed that Dr. Sherman had evaluated him on the 23rd, correct?

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A. When I dictated this, I considered the document to be accurate.
When I reconsidered a reiteration of Dr. Sherman's deposition, I came to understand that the June 23 note was actually reference to the 17th of June and not the 23rd of June.
Q. You then indicate in the next paragraph, that "On June 27 his weight was reported at 150 pounds, which would indicate a 45-pound weight loss over the course of 12 days." Correct?
A. That's what it says, yes.
Q. And why do you say "12 days"?
A. I think from the intake at the jail. Maybe it would have been 11 days on the 16th.
Q. What day did he get into the jail; do you know?
A. June 11. I'm sorry.
Q. And what day did he die?
A. He died on June 27.
Q. So how many days was he in the jail?
A. How many days was he in the jail? Sixteen days.
Q. Is this another inaccuracy, factual inaccuracy in your report?
A. No, I don't know the -- I don't know when his weight was reported or --
Q. Well, you had all the records.

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A. I did.
Q. So it's not a factual inaccuracy, it is your opinion that the weight loss, however it was reported, occurred over a 12-day period?
A. It was reported to have occurred over a 12-day period. And there was a weight that was -- that was reported on June 27. I'm not sure where the -- where the admitting weight was obtained or where the earlier reference was obtained or what day it was obtained.
Q. Did you look at the intake documents?
A. I did.
Q. Did you find his weight there?
A. I believe the intake document reported 195 pounds.
Q. Did you see -- other than the 27th and the intake document, did you see any other time, in any of the medical records or any records of any kind, where he was weighed or his weight was written down at all?
A. No. He wasn't weighed until the 27th, by my understanding.
Q. Did you see any other time, in any of the records, whether -- where his weight was written down, other than the day he came into the jail and the day he left the jail dead?
A. His weight was reported the day he came in the jail, and his day -- his weight was recorded when he was

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weighed on the 27th.
Q. Then why do you write "12 days"?
A. I don't know. I don't recall why I reached that conclusion.
Q. Does it appear that that's another factual inaccuracy in your report?
A. It may -- it could be, depending on the reliability of the initial report of 195 pounds.
Q. I'm not talking about the weight; I'm talking about the number of days.
A. You just asked --
Q. I'm talking about --
A. You didn't ask it that way. Whatever you're talking about or whatever you meant to ask, that's not what you asked.
Q. Does it appear that your notation that his weight loss occurred over a 12-day period appeared to be another factual inaccuracy in your report?
A. No, it's just not consistent with the fact that his weight was reported on intake on the day that he entered. I'm not sure -- I'm not sure if there were any other references to his weight.
Q. I'm looking at your conclusions in the second paragraph, where you indicate "Cessation" after talking about benzodiazepines, "Cessation of these

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medications causes a, quote, "rebound," unquote, of arousal symptoms of increased anxiety, restlessness, motor tension, hyperactivity, and in extreme cases, seizures."

Did I accurately read that?

A. You did.

Q. It also, in extreme cases, may cause death as well, correct?

A. I think that's exceedingly rare, and I think that would be exceedingly extreme. The literature does not really reflect -- the literature is more reflective of how rare death is in benzodiazepine withdrawal as an isolated cause of death or an isolated incident.

MR. IHRIE: Mark this as Shiener Deposition Exhibit Number 3.

MARKED BY THE REPORTER:
DEPOSITION EXHIBIT 3
7:28 p.m.

MR. IHRIE: Do you want one?

MR. CHAPMAN: I think I have it. Well, yeah, let me have it.

BY MR. IHRIE:

Q. I'm going to show you what has been previously identified as Correct Care Solutions' materials with respect to benzodiazepine withdrawal, and I'm going to

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ask you to go --

A. Give me a Bates number.

Q. I don't think they're --

A. Yeah, they're numbered, lower left-hand corner.

Q. Oh, yeah, there are Bates numbers on them.

I'm going to ask you to look at -- first of all, look at 9690.

THE WITNESS: 9690?

MR. CHAPMAN: You mean -- it starts out at 692, 693.

MR. IHRIE: 692 -- 696. I'm sorry.

MR. CHAPMAN: Look at 696?

MR. IHRIE: Yeah, 696. I'm looking at them upside down.

MR. PERAKIS: Fourth or fifth page, Doctor.

BY MR. IHRIE:

Q. It says "696." Do you see the picture of what I'm going to, for lack of a better phrase, call grim death?

A. You mean the Grim Reaper.

Q. The Grim Reaper?

A. That's a scythe he's --

Q. And that's a scythe, yes. So we're on the same page then?

Will you please read that --

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A. Well, wait. I want to be careful in answering. We're on page --

Q. This one, Doctor.

A. 0696.

Q. Yeah, this one.

A. I don't think we're on the same page, because I don't think we're --

Q. Okay.

A. -- thinking along the same lines. But we are looking at the --

Q. We may not be.

A. -- same page of the exhibit.

Q. So please read the words that are on that page.

A. Which words? All the words or the ones that are bulleted?

Q. The ones that are bulleted.

A. Okay. I've read them.

Q. Out loud.

A. Oh, out loud. I'm sorry.

"Why do we care about benzodiazepine withdrawal? It is potentially life-threatening."

Q. Then there's a picture of the Grim Reaper.

A. There is.

Q. So apparently CCS, in their materials, felt that benzodiazepine withdrawal is potentially

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life-threatening, correct?

A. Well, I --

Q. Would you agree? Yes?

A. Wait.

I can't tell you what their feelings are. They put this in, and they said this. This isn't peer reviewed, and this isn't scientific, and my opinion is it's not -- to say that it's potentially life-threatening -- I would say that the potential is quite low --

Q. Okay.

A. -- and that there may be many reasons for them to -- for them to represent this.

Doesn't even say who prepared this or what the source of that information or the source of that conclusion is.

Q. Well, the only source we know is that it says, "CCS Correct Care Solutions" on the top left.

A. But we don't know who prepared it or...

Q. No, we don't know who prepared it.

Looking at your -- under conclusions, the third paragraph down, you indicate that "Short-acting drugs are excreted rapidly, leading to sudden decreases in serum level and intense withdrawal symptoms early in the course of abstinence."

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A. Yes.
Q. What intense withdrawal symptoms, if you know?
A. Well, all the symptoms are present more intensively, because they occur suddenly, over a shorter time period.
Q. What symptoms?
A. All the symptoms that I measure; arousal symptoms: increased anxiety, restlessness, motor tension, hyperactivity. And -- and with sudden, rapid falling serum levels, the risk of all of these symptoms, including seizures, is heightened.
Q. What does "early in the course of abstinence" mean?
A. Well, the period of abstinence -- the length of abstinence determines the likelihood of the symptoms of an abstinence syndrome. And the symptoms generally peak with alcohol, say, within 72 hours. With benzodiazepines, with the shorter-acting drugs it may occur -- the abstinence syndrome may begin to emerge in as short as 12 or 24 hours; whereas with longer-acting drugs, the onset of symptomatology might occur later, 24 or 48 hours.
Q. Are there different stages of benzodiazepine withdrawal?
A. Well, sure. The -- the withdrawal and the development of abstinence syndrome is a function of how long

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someone has taken a drug and how much they've taken. So in general, someone who takes a lot for a shorter period can experience withdrawal symptoms, someone who takes a little bit for a longer period can experience withdrawal symptoms, if they stop taking the drug suddenly.
And then the other factor of how soon the symptoms emerge has to do with the excretion curve of the drug. So a drug -- and the examples I give, oxazepam, temazepam, and lorazepam, those are drugs that have no active metabolites, they have a relatively short duration of action, so the symptoms may occur within 12 or 24 hours of cessation; whereas with drugs like alprazolam, clonazepam, or chlordiazepoxide or chlorazepate, which have a longer duration of action, the symptoms may not emerge for 24 to 48 hours or even 72 hours.
Q. So without knowing how much somebody was taking, the frequency of their dose, the size of the dose, how long they had been taking a drug, and when the last time they used it, all of those may be variables with respect to the onset of symptoms. And this -- let's just do those -- with the onset of symptoms, correct?
A. Well, I think the onset of symptoms has more to do with the duration of action of the drug.

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Q. All right. So onset has more to do with duration, correct?
A. Duration of action has more to do with onset.
Q. All right. Duration of action means how long somebody's been taking the drug?
A. No. Duration of action is how long the drug's action is present. So if you take a dose of Ativan, lorazepam, that's relatively short acting. So -- and if you take that on a regular basis and stop taking it, abstinence syndromes will emerge sooner after abstinence is induced. Okay.
So whereas if you take a longer -- a drug with a longer duration of action, and you stop taking it suddenly, abstinence syndromes may appear later in the abstinence.
Q. What if you're taking both?
A. If you're taking two drugs, the way they interact, what you've taken most recently, how much you have on board determines how soon the abstinence syndrome emerges.
Q. And when they peak also; would derm -- would be important to determine also when they peak?
A. Yeah, I mean the difference would be 12 hours versus 48 to 72 hours.
Q. And would it also be a factor in determining how long

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the peak symptoms last?
A. No, no, that's -- once the syndrome is established, the -- you know, the syndrome lasts for as long as it took to develop. So if it peaks at 12 or 24 hours, then the second 12 or 24 hours are the duration of the abstinence syndrome. If it peaks at 72 hours, it may be another 72 hours.
Q. Have you ever written any articles on benzodiazepine withdrawal?
A. I wrote an article in a journal called Patient Care, and I talked about hospital delirium, and that addressed benzodiazepine withdrawal. I wrote a --
Q. Can we get a copy of that article?
A. Oh, I don't -- it's old, and I don't have a copy, so I don't know where you'd get it.
And then I wrote a chapter in a textbook called The Clinical Practice of Emergency Medicine that talked about acute psychosis and altered mental status that may have mentioned abstinence syn -- nothing of the depth to which we're discussing at this point.
Q. Your next paragraph says, "Based upon the length of time that Mr. Stojcevski was in the hospital."
What hospital was he in?
A. Not in the hospital; in the jail. That must be a

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typo.

Q. Well, it's not really a typo; it's a different word. Is that another factual inaccuracy in your report?

A. I'd say it was more like a typographical error or dictation error. He wasn't in the hospital; he was confined.

Q. Then you say, "Based upon the time that he was in the hospital and the" -- and this is what I'm going to ask you about -- "the development of his symptoms."

Describe the development of his systems -- symptoms for me, please.

A. I'm not sure what you're asking.

Q. Well, you used the phrase, "the development of his symptoms."

A. Well --

Q. I presume that means that his symptoms developed, correct?

A. His behavior became disorganized early on in the hospitalization.

Q. I want you to describe the development of his symptoms.

A. Yes. Well, what I would say is that his behavior became disorganized early in the stages of his confinement and were intermittent but persistent throughout the 16 days.

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Q. What symptoms developed?

A. Disorganized behavior.

Q. Well, that's a term of art. I want you to talk to a layperson.

A. We've talked -- we talked about disorganized behavior for about 30 minutes earlier in this proceeding.

Q. Well --

A. And I gave examples, and I talked about the things that were represented in the record, or the descriptions: staring, not responding, engaging in behavior that Dr. Sherman said was not consistent with a -- with a seizure.

Q. The hallucinations, too?

A. Well, the report that half of his -- half of his body had been devoured or half of his heart had been devoured.

Q. When you say, almost sarcastically, Well, the report that he did that, I mean, are you somehow suggesting that what he said somehow is not a hallucination?

MR. CHAPMAN: Wait. I'm going to object to the use of the term "sarcastic." There's nothing about Dr. Shiener's testimony that --

MR. IHRIE: It appeared to me to be.

MR. CHAPMAN: -- was sarcastic. Well, then you appeared wrong.

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THE WITNESS: If I'm being sarcastic, you'll know it, and it won't just appear that way.

I don't mean to be sarcastic. I'm trying to be precise when people use jargon or terms of art that might not be appropriately used. And someone said -- someone said in the record "hallucination," and then the behavior to which they seemed to be referring was that the patient said that half of his body had been devoured or half of his heart had been devoured. That would be more -- and you raised the question of a delusion. That would be more consistent with the description of a delusion than a hallucination.

But it's a representation of disorganized behavior.

BY MR. IHRIE:

Q. So there are no other symptoms, other than the ones you have mentioned in this deposition, that fall under the umbrella of your phrase "development of his symptoms;" is that true?

A. Well, now we're debating this to quite an extensive degree, but what I would say is: The things that I have described.

Now, there is some mention of an elevation of blood pressure with a diastolic of 95. And

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depending on what his baseline blood pressure was, elements of hypertension can be determined by a number of things, but blood pressure, especially diastolic blood pressure, but often pulse pressure as well or the width between diastolic and systolic, can be elevated in the abstinence states from sedatives or hypnotics or alcohol. So the development of that symptom.

His intermittent intake of food, his being incontinent of stool, the time at which those things occurred, and the duration for which they presented on an intermittent basis are what I'm referring to as the development of symptoms.

Q. Would your development of symptoms also include observations by personnel of rapid-eye movement?

A. Well, first of all, it's not my development or not my description, it's just -- it's a term that I use, something that --

Q. Yes.

A. -- something that --

Q. Would the term that you used, "development of his symptoms," also include observations by others of -- that he had rapid-eye movement?

A. Well, rapid-eye movement refers specifically to a phenomenon that occurs in a certain stage of sleep.

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And then rapid-eye movement can be -- can mean nystagmus, it can mean glances that are darting around the room. That might be the indication of hallucinations. So if I'm talking to you, and I keep looking over here, and you were a psychiatrist, you might infer that I was seeing something or looking at something or sensing movement, and then the prudent thing for a psychiatrist to do would be to ask a patient, "Is there something that you see, or is there something distracting you."

But -- so rapid-eye movement is very nonspecific. And typically rapid-eye movement is more of a symptom of intoxication with certain drugs of abuse rather than something that's seen in withdrawal state. But when patients have visual hallucinations, their eyes may be described as darting. I don't know that I would necessarily consider that to be rapid-eye movements.

Q. What about eye fluttering?

A. Eye fluttering is something that's seen when someone is falling asleep, or when someone is just inducing sleep, and it's another phenomenon that some individuals who are described as histrionic often do when they're thinking or when they're under stress, where their eyelids flutter.

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Q. How about incoherency?

A. Incoherency is very nonspecific.

Q. Is that part of the development of his symptoms that you --

A. Well, he was described as incoherent. It's not really -- and what they mean was he was making verbalizations that didn't seem to make sense. That might be some -- that might be one of the symptoms, and that could emerge in a number of conditions, benzodiazepine withdrawal being only one of them.

Q. I appreciate that comment, but my question is: Is incoherency one of the symptoms that you're talking about when you talk about "and the development of his symptoms"?

A. Well, the description of him as being incoherent may refer to one of those symptoms. Again, I don't mean to be sarcastic, but these are mental health professionals who are using conclusory terms or jargon rather than descriptive terms. So when you say someone's incoherent -- you've taken a lot of depositions, and you've gotten answers you don't understand. You might use the term incoherent.

When I describe someone as incoherent, what I would do is in a report I would describe what they said, and then I would refer to them in the summary as being incoherent, meaning that they make verbalizations that don't make sense or that are difficult to understand, or it's difficult to understand the relevance or the context of what they're saying. That's what I would mean.

I don't know what these people mean.

Q. Well, when I asked you about these symptoms, you seemed to preface your answers with, Well, you know, somebody's saying that they observed.

All of the symptoms are what somebody say they observe; are they not?

A. They're -- they're not describing their observations; they're making conclusory statements.

Q. You mean I can't walk out here and listen to somebody walk up to me on the street and have them talk gibberish, and I'm not qualified to say that they're incoherent?

A. Yeah, because they might be talking to you in another language. And you might describe it as gibberish, and it might be an eloquent dissertation in some language that you don't understand.

Q. So the answer to my question is: Yes, that I'm not qualified to know if somebody is speaking in an incoherent fashion. Is that your testimony?

A. No, my testimony is that: If you described someone speaking what you refer to as gibberish as being incoherent, that may not be accurate, and that would be a conclusory statement.

If you said that someone came and spoke to you in words that you didn't understand, and it could be gibberish or it could be another language, that would be more accurate. That would be an observation.

Gibberish is a conclusion. Incoherence is a conclusion.

Q. Trust me, I know if somebody is speaking incoherently.

A. It's not a question of my trust or distrust.

Q. So what about tremors; I haven't heard you use the word tremors. Are tremors one of his symptoms in your "development of symptoms" phrase?

A. Tremors could -- tremors could be one of the symptoms that could be caused by benzo --

Q. I'm not asking --

A. If he developed tremors, that would be one of the things to which I was referring.

Q. What -- I didn't hear the end of that.

A. I said, "If he developed tremors, that would be one of the things to which I'm referring."

I just don't want to end a sentence with a preposition.

Q. Thank you.

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19:47 **A. I don't want to say referring to.**
19:47 Q. I'm sorry to say that you're old school. Me too.
19:47 **A. Well, I'm also old, so...**
19:47 Q. You know, that's hard to hear "Where are you at," but we hear it.
19:48 **A. Try working with medical students every day who can't speak proper English --**
19:48 Q. Try hiring a lawyer --
19:48 **A. -- let alone use jargon, so...**
19:48 **Takes two of them to do this.**
19:48 Q. We talked about decompensation before. You understand because you reviewed the document, that the word decompensation is one of the categories that is on the self-harm watch mental health observation initial assessment as -- it's one of the categories under the heading "Reason to Watch." So -- did you know that?
19:48 **A. Yeah. I got the form right here.**
19:48 Q. All right.
19:48 **A. I have the form on my screen.**
19:48 Q. Well, you implied when I asked about decompensation, Well, it's -- you know, people say things, and decompensation really isn't --
19:48 **A. Look, that's an issue that I have with using jargon terms and not being descriptive. And I think that that makes the -- that makes what -- the terms are**

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19:49 **nonspecific, they're used in an imprecise manner; and it's better to describe what you're seeing.**
19:49 **Now, I know what decompensation means, but it's commonly used even by many mental health professionals, in a cavalier way or an imprecise way.**
19:49 Q. Was it being used in a cavalier way when the mental health professionals checked decompensation in this case?
19:49 **A. Well, I would describe the disorganized behavior as evidence of a decompensation, meaning the definition that I gave you about an hour ago. But I just -- whenever these jargon terms or terms of art are used, I feel I have to give a caveat. And I don't mean to be difficult.**
19:49 Q. You then indicate under -- "and the development of his symptoms, a time course is not suggestive of withdrawal from benzodiazepines, and the more severe aspects of Mr. Stojcevski's condition in the latter stages of his" -- there's that typo, hospitalization -- "hospitalization, a period of 16 days, is not consistent with -- is not consistent withdrawal from benzodiazepines."
19:50 I'm going to suggest that probably is a typo. You missed a word, correct?
19:50 **A. With should be in there. With withdrawal. It's not**

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19:50 **-- that's not an uncommon thing for a typist to miss.**
19:50 Q. I agree.
19:50 So tell me what the, quote-unquote, "more severe aspects of Mr. Stojcevski's condition in the latter stages of his confinement" were.
19:50 **A. Well, his behavior seemed to be -- seemed to be described as being more disorganized, he was eating intermittently, his verbalizations were not making sense, he's -- there was incontinence of stool.**
19:51 **So there's -- the behavior seemed to be becoming more disorganized towards the end of his confinement.**
19:51 Q. Meaning that his condition was deteriorating?
19:51 **A. Well, manifestations of some process were becoming more obvious and presenting more --**
19:51 Q. "The manifestations of some process" --
19:51 **A. That's right.**
19:51 Q. -- "were becoming more obvious."
19:51 **A. That's right.**
19:51 Q. What manifestations?
19:51 **A. The things we've been talking about.**
19:51 Q. All of them?
19:51 **A. The progression of symptoms.**
19:51 **All of them in varying sequences, in varying degrees at different times.**

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19:51 Q. So all of the things that we were talking about were becoming more obvious --
19:51 **A. More manifest and more obvious, which is --**
19:51 Q. -- the longer he was in the jail.
19:51 **A. That's right. That was the trend.**
19:52 Q. I'm not going to spend much time on it for my friend Ron, but why did you go into much detail about opiate withdrawal? Why is that important in your conclusion here?
19:52 **A. Well, because he was taking -- he was reported to be taking methadone as well.**
19:52 Q. Well, you indicate that "Once again" -- and I'm looking at the first full paragraph on five. "Once again the course of Stojcevski's symptoms would suggest that the more severe symptoms that he experienced were unlikely to be caused by opiate withdrawal, as opiate withdrawal symptoms usually peak within 72 to 96 hours and remit shortly after that."
19:53 **A. That's right.**
19:53 Q. Okay. Then you indicate "Based" -- in the next paragraph, "Based on my review of the medical records and the course of Mr. Stojcevski's illness, an alternative consideration is strongly suggested."
19:53 I want to talk about your phrase "strongly suggested" for a minute. "Strongly suggested" is a --

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is a categorization that would be compared to what?
A. A categorization compared to what.
Q. Yeah. Let me tell you --
A. I don't understand what that means.
Q. Fair question.
What came to mind when I was thinking about this, when I saw your phrase "strongly suggested," was: not suggested, moderately suggested or somewhat suggested, suggested, strongly suggested, true.
Do those make sense in terms of the categories? Because you're using a phrase that I don't have anything to weigh it against, "strongly suggested."
A. Well, it sounds like you do. Because it sounds like your response was that whole hierarchy.
Q. Does that make sense to you, those categories?
A. Well, I want to be careful in answering this.
It seems consistent with what I know about how lawyers think.
Q. How about how you think?
A. No. No.
Q. How --
A. Strongly -- look --
Q. I'm not trying to trick you.
A. No, I --

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Q. I'm just trying to get some bearing on what you mean.
A. I didn't say you were trying to trick me. I was about to explain.
A doctor's job is to look at a bunch of phenomena and to find a pathophysiologic process that explains all the phenomena. And the suggestion -- at least the suggestion or the inference throughout my analysis of the -- of the course, the correspondence between the lawyers, and the considerations or the suggestions or the inferences to be made from the course of Mr. Stojcevski's confinement in the jail was that his use of opiates and his use of benzodiazepines had something to do with his demise, and that this had something to do with an abstinence syndrome. And when I discussed that on page 4, I thought I discussed those issues in some detail, to suggest that: What happened to Mr. Stojcevski was not consistent with what we know about opiate withdrawal because of the time frame, and because of the -- the bottom line with opiate withdrawal, that it's more physically uncomfortable than life-threatening.
And the morbidity of -- the morbidity from opiate withdrawal is -- is very limited. People are uncomfortable for --
Q. Well --

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A. Wait, wait. Let me finish.
-- for a brief period.
Looking at benzodiazepine withdrawal, that occurs early on in the course of abstinence, hours or days, and it's unlikely that an abstinence syndrome could persist for more than several days. Certainly not for 16 days.
Q. So this first -- second full paragraph on page 5, getting back to that, you say that, "Mr. Stojcevski's illness" -- I'm sorry, let me start, "Based on my review of the medical records and the course of Mr. Stojcevski's illness, an alternative consideration"...
Now, your word "an," does that mean that there are other alternative considerations, or you're just sort of picking out one, "an alternative consideration"?
A. No, I'm describing what my thinking is.
Q. Is it the alternative consideration, or is it one of many?
A. Well, in medicine, a doctor considers a differential diagnosis. So there are many things that a doctor considers.
What I mean to express here -- and you can diagram my sentences, if you like, but what I mean to

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express is that a -- a more compelling conclusion than the influence of opiate withdrawal or benzodiazepine withdrawal or some combination of the abstinence syndromes from those two substances --
Q. Um-hum.
A. -- was responsible for what happened to Mr. Stojcevski.
Q. Um-hum. So what is a neuroleptic?
A. A neuroleptic is a drug that -- a neuroleptic is a drug that causes what -- the Swiss chemist who described it used the term la affect neuroleptic (phonetic). Emotional quieting, less interest in the environment, subdued reactions separate from sedation.
Q. And --
A. And neuroleptic drugs are typically drugs that have some effect on the dopamine system in the mind and cause that syndrome of emotional quieting.
Q. Does Xanax have any effect on the dopamine system of the brain?
A. Not any direct effect.
Q. How about --
A. All these systems interact with each other. But Xanax affects GABA, the chloride channel, and glutamate.
Q. And can you tell me the difference, if there is a difference, between a neuroleptic and a psychotropic

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medication?
A. Well, psychotropic is a class of medicine that have an effect on the psyche or the mind, and a neuroleptic is one of those drugs.
Q. So a neuroleptic would fall under the umbrella of psychotropic?
A. Neuroleptic drugs are psychotropic drugs.
Q. But a psychotropic --
A. Wait, wait, wait.
Q. I'm sorry.
A. You have to be very careful, because neuroleptic drugs are used for a number of different things. Neuroleptic drugs all have an antiemetic quality.
Q. Anti what?
A. Antiemetic. They block vomiting or nausea. Neuroleptic drugs, many of them are antihistaminic, so they're used for itching, used to stop itching. So -- but neuroleptic drugs are psychotropic drugs. They do have an effect on the psyche, and their indication is some aspect of mental illness, either mood stabilization or treatment of psychosis.
(Recess taken at 7:59 p.m.)
(Back on the record at 8:05 p.m.)
BY MR. IHRIE:

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Q. So looking at the same paragraph, you indicate -- well, is Xanax a psychotropic medication?
A. Any drug that affects the mind. And Xanax is a psychotropic medicine, because it's used as an anxiolytic.
Q. And Klonopin?
A. Well, Klonopin is, but Klonopin's FDA indication is for -- as an adjunct anticonvulsant. It really doesn't have FDA approval as an anxiolytic.
Q. Alcohol?
A. Alcohol is a psychoactive drug; it's not a psychotropic drug. The term psychotropic is typically reserved for drugs that have a therapeutic effect. And they serve alcohol in nursing homes, and, you know, there are some nursing home residents that take a shot of whiskey or a shot of -- a glass of wine at bedtime, but it's considered a psychoactive drug; not a psychotropic.
Q. So you indicate in this paragraph, "Individuals who use psychotropic medications often experience more life-threatening conditions, neuroleptic malignant syndrome."
A. Yes.
Q. Is that -- when you say, "neuroleptic malignant syndrome," are you talking about -- when you say "more

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life-threatening conditions," such as neuroleptic --
A. That's right.
Q. That's what you basically are saying?
A. Yes. Um-hum.
Q. Okay. Now, describe for me what neuroleptic malignant syndrome is.
A. Well, neuroleptic malignant syndrome is a syndrome that occurs when patients receive neuroleptic drugs, and they develop delirium, lead-pipe rigidity, or what's called a whole-body dystonic reaction: elevated fever, elevated white blood cell count. And that has a certain degree of mortality as well as morbidity.
Q. Then you say, "Although there's no indication that Mr. Stojcevski received neuroleptic medication."
A. That's right. Well, that's one of the things to consider in the differential diagnosis, is the only reason I'm putting it here.
Q. So if he never -- I want to call it NMS. If NMS is for people who have been taking a neuroleptic --
A. That's right.
Q. -- and you have no evidence that he was taking any neuroleptics, and he was never described as having what you call "lead-pipe rigidity," why do you identify it as a -- why do you even talk about it?

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A. It's part of the differential diagnosis of a condition that presented with the course of Mr. Stojcevski's confinement.
Q. I'm not sure that I understand that. And maybe it's because I'm not medically smart. But when you say "it presented itself," how did it present itself?
A. No, I didn't say -- no, that's not what I said.
Q. All right.
A. What I said was: That's part of the differential for someone who presents as Mr. Stojcevski did. But it's ruled out for the reasons that you just discussed or the reasons that I state. There's no -- there's no indication that he ever received neuroleptic medication, and he was never described as having any of the symptoms -- any of the symptoms that are specific to that syndrome, other than delirium.
Q. Well, is that -- are you finished?
A. Yes.
Q. Okay. Is that -- is NMS one of the alternative considerations that you're strongly suggesting?
A. It's part of the differential diagnosis, but it's not suggested by the symptoms.
Q. What was suggested by the symptoms?
A. Malignant catatonia or catatonia.
Q. And that's in your next paragraph.

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A. That's right.
Q. And you indicate in the next paragraph, "Another syndrome would be."
When you say "would be," you mean is an alternative that is strongly suggested?
A. That's right.
Q. What's the difference between malignant catatonia and catatonia?
A. Well, catatonia can be self-limiting, and some patients develop some of the symptoms, or a milder form of the illness, and then either remit or respond to treatment. But other patients have a steadily deteriorating condition that leads to some morbidity or death.
Q. And which one are you saying it strongly suggested?
A. Malignant catatonia.
Q. And what are the -- when it says -- your last paragraph says, "Catatonia is the delirium and altered level of consciousness."
How are the last two paragraphs on this page related to one another?
A. (No verbal response.)
Q. You talk about malignant catatonia in the second-from-last paragraph, and catatonia in the last one. Or are they -- should I read them connected

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together in some way?
A. I don't really know what you're asking. I talk about the condition of catatonia in two paragraphs.
Q. Well --
A. How are they -- how are they different?
Q. All right. Well, let me ask you --
A. Wait, wait, wait, wait, wait.
I think the first paragraph is more descriptive of catatonia, the second paragraph talks about some of the consequences or the possible outcomes of catatonia.
Q. I guess the reason that I ask you that is because under the last paragraph, where you say "Catatonia is," you have a whole bunch of symptoms. The one when you talk about "malignant catatonia," you don't identify any symptoms in that. So that's what I'm trying to figure out.
Let me just ask you differently.
What are the symptoms of malignant catatonia?
A. They're the same symptoms of catatonia.
Q. Okay.
A. It just becomes more persistent, the symptoms may be more severe, and it progresses to a poorer outcome.
Q. I see.

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So the symptoms of catatonia on DSM-5 -- I'm going to list them. There are 12. Stupor -- did you see stupor?
A. Well, delirium, the altered level of consciousness.
Q. So you would say that delirium falls under a category of stupor?
A. Well, he was described as incoherent, or he had problems -- you know, we've talked about this all evening. He had problems taking in information, processing it, and acting on it. Being stuporous or being less active or staying in one place and -- and/or having movements that are -- movements or actions that are purposeless, would be one way to -- could be described as stuporous.
Q. Catalepsy? Did he have catalepsy?
A. I think on the videos there were some times where he was active, and then he would suddenly become inactive.
Catalepsy refers to a very specific phenomenon that is common to a number of neurologic syndromes, where someone -- where someone becomes suddenly inactive, or someone suddenly -- somebody is doing something, and they suddenly stop, or they suddenly drop.
Q. Well, the DSM-5 describes catalepsy as passive

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induction of a posture held against gravity. Do you agree with that?
A. That's waxy flexibility.
Q. Well, that's not what the DSM-5 says. Do you disagree with that DSM-5 description?
A. No, that's -- staying in one posture, that's a rare symptom of catatonia.
Q. But it wasn't what you described, was it?
A. No. It's sudden cessation of a movement. So in the middle of doing something, someone just stands still, and they stop. That's what I said.
Q. Did that ever happen with David?
A. Well, there were -- his activities were described as purposeless. I don't know that anyone described that specifically.
I fast-forwarded through much of the videos. There might have been some instances where he was doing something, and then he -- and then he suddenly ceased. I -- I don't know that I would necessarily interpret it and use that -- that term or that --
Q. Did he have waxy flexibility?
A. Nobody ever put him in a position and determined -- you have to test for that. So if you see someone, you raise their hand. If they're catatonic schizophrenic,

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they're often negative, and they resist you. If they're just stuporous or delirious, they won't resist you; but if you let go of their arm, it will fall. If they're catatonic, they'll keep it in the same position. No one ever tested him in that way.

Q. Did he have mutism?

A. There were times where he wouldn't speak. They said that he refused to speak or was incapable of speech.

Q. Who said that?

A. I don't recall, but there are notations in the medical record.

And we talked about refusing to speak versus being incapable of speech.

Q. Did he have negativism?

A. Negativism is different than cataplexy. Negativism is when you go to move -- someone is in a resting position, they seem to be inattentive, you go to move their arm, and they resist you. And then their eyes are closed, you try to open their eyes, and they scrunch down, keep their eyes closed.

Nobody ever tested him for that, either.

Q. Was there any posturing?

A. There were times where he -- where he was described as not moving.

Q. Posturing -- what is posturing?

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A. Well, posturing is more what they describe in cataplexy. Someone stays in an awkward posture, or is doing something, they suddenly stop, but they stay in the position that they were in when they stopped.

Q. DSM-5 says, "Posturing is spontaneous and active maintenance of a posture against gravity."

Did you see any of that?

A. I didn't see any of that on the video.

When they say "against gravity," that might mean holding one's arms out or holding one's arms in the position that they were in the last time they did something, or standing as opposed to laying flat on the bed or laying flat on the ground.

Q. I hope I pronounce this right. Stereotypy?

A. Stereotypy means doing the same thing over and over again. I think I saw some things on the video where he would -- where he would do that. That's more purposeless. And stereotypy might be moving your hands around in a circle or touching the same thing or rubbing the same thing. I thought I saw some things that were consistent with that on the video. No one ever described that or used that term.

Q. Agitation?

A. Agitation is pretty nonspecific.

Q. Grimacing?

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A. Nobody described him as grimacing.

Q. Echolalia?

A. Nobody used that term to describe him, either.

Q. I know they wouldn't use that term, but did they describe that condition?

A. Echolalia is quite rare. No, nobody said that he just repeated what was said to him.

Q. And the same goes with echopraxia, correct?

A. That means doing the same thing that someone does. And no. That's the opposite of mutism.

Q. So --

A. So there's a whole range of behaviors, some being the opposite of other behaviors that you see.

Q. So for catatonia DSM-5 says, "The clinical picture is dominated by three or more of the following symptoms."

Did he have three or more?

A. Well, first of all, that's only a guideline. I don't want to endorse that. That's authoritative, and I don't want to endorse that the DSM is like a book of statutes, where you have to have something to make the diagnosis. If you read the book properly, and you read the disclaimers about the use of the book and about clinical judgment and clinical experience -- I believe if you read through them, I believe he had -- he had stupor, he had some evidences, by my

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recollection, of stereotypy, he had some -- he had elective mutism, so that's three right there.

Q. Do you have access to the video right there?

A. No, I don't. This is a new computer that does not play videos. It won't play DVDs.

Q. Okay. Where do convulsions fit into --

A. Convul -- you mean seizures?

Q. No, convulsions. Where somebody is lying on the ground, and then they -- I know that this won't be picked up by the -- they just begin to just --

A. That's a --

Q. -- go -- just act like this.

My arms and legs are flying all over, for the record.

A. I wouldn't call -- that would be flailing arms and legs.

Q. All right.

A. That's not necessarily typical in catatonia.

Q. Where does apparent --

MR. PERAKIS: Did you hear what he said? "That's not necessarily typical in catatonia."

BY MR. IHRIE:

Q. And where -- presuming that such physical behavior was not intentional, what would that seem to indicate to you?

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A. It was not intentional?
Q. Yes.
A. It could be an indication of physical discomfort; it could be an indication of alteration in sleep/wake cycle, someone might be thrashing about while they're dreaming; it could be manifestations of a seizure; could be feigning a seizure, as Dr. -- as Dr. Sherman concluded, based on the fact that he made verbalizations after the behavior was observed.
Q. What kind of verbalizations?
A. (No verbal response.)
Q. When you say "he made," you mean David made, David Stojcevski?
A. Well, let me...
Okay. This late entry that's referenced to 6-23 --
Q. Um-hum.
A. -- that in fact is 6-17, "I went to see the patient who was being observed in the medical unit for questionable seizures. I observed him fluttering his eyes in what was certainly not a seizure but what was most likely his poor attempt to feign one. I shook his shoulder and told him to sit up, at which point he suddenly stopped the eye fluttering behavior and exclaimed, 'What's happening,' as if he was unaware."

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So that verbalization would be inconsistent with a seizure or paroxysmal event.
Now, if someone were flailing their arms -- what you demonstrated is not consistent with a neurological symptom of a seizure.
Q. I never said it was. I just asked you what it would be an indication of.
I think you've answered the question to the best of your ability.
A. I think a lawyer trying to demonstrate something and not really knowing what he was trying to demonstrate.
Q. Oh, I knew exactly what I was trying to demonstrate.
A. What was that?
Q. It was exactly what he does on the tape. If you pull it up, I'll show it to you.
A. Well again, that flailing -- flailing is not consistent with a paroxysmal event or a seizure.
Q. I didn't say it was. I just asked you what was it an indication of, and I think you answered the question.
A. But you referred to it as a convulsion.
Q. Yes, I did.
A. And convulsion is generally synonymous with seizure.
Q. Okay. You read Dr. Sherman's deposition, correct?
A. I read Dr. Sherman's deposition.
Q. And you must have read, when you read his deposition,

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that Dr. Sherman testified under oath that David never said he was having a seizure.
Do you recall reading that?
A. I haven't committed it to memory. If you want to direct me to a page, I'll --
Q. That he -- do you remember reading that he testified that he never even used -- that David never even used the word seizure? Do you recall reading that?
MR. CHAPMAN: I'm going to object to the form and foundation. It's not a memory test. If you want to direct him to a page, you can do that.
THE WITNESS: I haven't committed it to memory. In the interest of accuracy, if you want to direct me to a page, I'll review that.
BY MR. IHRIE:
Q. Um-hum.
A. What page?
Q. Well, let's ask it as a hypothetical question.
I want you to assume hypothetically that a patient comes down to a medical doctor in a jail setting, and the medical doctor concludes that it was -- that the patient was feigning a seizure, and that the patient never used the word seizure. I want you to assume that the patient never said he was having a seizure, I want you to assume that the doctor says

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that none of the physical movements that he was exhibiting even indicated a seizure. I would like you to tell me, given those circumstances, do you have an opinion as to why a doctor would conclude that he was feigning a seizure?
MR. CHAPMAN: Object to form and foundation. Calls for a conclusion, calls for speculation, and you're not informing him of the entire record, only the selective parts you want to inform him of.
MR. PERAKIS: That's the nature of a hypothetical.
MR. CHAPMAN: No, a hypothetical must include all the relevant facts. You can't --
MR. IHRIE: Those are all the relevant facts.
MR. PERAKIS: Those are the relevant facts.
MR. CHAPMAN: No, it's not.
MR. IHRIE: Well, that's your opinion. Make your objection.
THE WITNESS: If I'm to reach an opinion based on what you've told me, what I would say is that a medical doctor working in a correction setting would have to have a high index of suspicion for malingering, especially someone who's in a mental

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health unit and someone who's newly admitted. And if someone is seen flailing their arms in the manner in which you demonstrated --

BY MR. IHRIE:

Q. Yeah? Well, no, I'm not -- Doctor, don't --

MR. CHAPMAN: Wait. Let him finish his answer.

MR. IHRIE: I don't want him to misunderstand something.

BY MR. IHRIE:

Q. My flailing was in no way intended to indicate that that was in any way related to the time when he saw Dr. Sherman.

A. Well, but you said that was exactly what happened on the tape.

Q. It was, but -- it is, but not when he saw Dr. Sherman or before he saw Dr. Sherman. That occurred well after he saw Dr. Sherman. So I don't want you to misunderstand.

MR. CHAPMAN: Did you have a question for the doctor?

MR. IHRIE: Yeah. He was in the process of answering my question.

MR. CHAPMAN: Well, you interrupted him.

THE WITNESS: What I said was: In a

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correction setting, a doctor has to have a high index of suspicion for malingering or the intentional production of the symptoms of a physical or psychiatric illness for the sole purpose of secondary gain or external consequences, which might be medication, transfer to a better unit, attention, or avoidance of an unpleasant aspect of his confinement. And so that index of suspicion must be there.

And if the behavior that the doctor was asked to observe involved involuntary movements in a patient that he knew or suspected had been using drugs or taking -- taking sedatives, it's not an unreasonable inference to conclude that this would be a naive attempt to feign a seizure. And I believe that -- I believe that in some of the things that I read, there's some -- there may have been some inference that the doctor was called to see the patient because of the possibility that the patient may have been having a seizure.

And I don't want anyone to infer that just because a doctor concludes that a patient is feigning a seizure, that the patient would have to mention seizure or use the word seizure or overspecify his symptom in some way.

And "overspecify" means drawing attention

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to a symptom, which is a common finding in malingerers.

BY MR. IHRIE:

Q. You would agree though, wouldn't you, that if a doctor is to conclude that a patient is feigning a seizure, that there has to be something that was presented by the patient that somehow relates to seizure activity or seizure-like activity; would you not?

A. Well, when you say "something," that's imprecise. What do you mean? What do you mean when you say "something"?

Q. Well --

A. Well, wait.

If the patient was acting in a way that made another health care professional concerned, and called the doctor and say, "Doctor, this patient's behaving in a certain way, is he having a seizure," then that would be the first thing on the doctor's differential.

Q. Is malingering a diagnosis?

A. No, but it's called a V-code. It's -- malingering is --

Q. It's not a diagnosis, is it?

A. No, it's not a diagnosis.

Q. Would you agree with this statement? "Even advanced

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providers need to be very cautious about deciding that a patient is malingering. One correctional physician," and it gives the name, "asserted that malingering must always be considered a diagnosis of exclusion. Literally every other possible cause of the patient's symptoms must be ruled out before deciding that the patient is malingering."

Would you agree with that statement?

A. Well, if --

Q. I'll let you explain yourself, but give me a yes or a no, if you agree with it.

A. Well, that's a lengthy and very conclusive statement, and there are parts of it which I -- with which I don't agree.

Q. With which what?

A. With which I do not agree.

Q. Okay. Well, just so you're aware, you didn't agree with language from the people who are paying you in their patient malingering nursing perspective from Correct Care Solutions' cover article.

MR. CHAPMAN: Is there a question in that?

BY MR. IHRIE:

Q. Did you know that?

A. Did I know from what you were reading? No, I didn't know what you were reading.

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MR. CHAPMAN: It's not an authoritative document. Come on.
MR. IHRIE: Well, hold on.
All right. Do you want to take a break?
MR. PERAKIS: Yeah.
MR. IHRIE: Okay. Last break, I think.
THE WITNESS: How much longer do you think you have? Another hour?
MR. CHAPMAN: How much time do you think you have?
MR. IHRIE: Ten minutes.
(Recess taken at 8:30 p.m.)
(Back on the record at 8:35 p.m.)
MR. IHRIE: Back on the record.
BY MR. IHRIE:
Q. I will read that paragraph again to you, but I'd like you to tell me which portions of it you don't agree with.
A. Oh, you don't have to read it. I'll tell you.
Q. Okay. Go ahead.
A. The idea that malingering is a diagnosis of exclusion, you need positive findings to make the diagnosis as well as having ruled out -- ruled out other conditions or other possible physical explanations. But the sentence -- but the paragraph that you read to me made

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it sound so absolute. And in medicine -- this may get a little conceptual, and this may be a little long-winded, but first of all, it's impossible to prove a negative, and you cannot prove that somebody's not sick. And with all of our investigations, imaging studies, blood tests, physical examination, you still cannot prove a negative, that someone is not sick.
Medical problem-solving means that a doctor listens to a symptom, thinks of the most severe illness that could be causing the symptom, undertakes a history and an examination to make the patient prove by his signs, symptoms, and history that he has that condition. And then if a patient can't prove that, then you go to another condition.
So if you come to me with chest pain, my first thought is myocardial infarction or acute coronary syndrome. So I'll ask you a question that will rule that out. And that question would -- that question would be, in a rational approach: "Where is the pain?"
You must point to your left side. If you point to your right side, then I have to come up with another diagnosis. But I can't prove that you're not having a heart attack; I can only prove your symptoms aren't consistent with that. And if I keep on going

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down a differential diagnosis, I might find some condition that's most consistent.
So if your pain is right-sided, then it may be pleuritic, a problem between the lungs and the lining of the chest cavity; it may be referred from your gallbladder; it may be a subdiaphragmatic abscess; it may be cervical pain radiating down; it may be an abscess in your axilla. So I'll ask you a series of questions to rule out those things.
Q. You mean you'd follow up on things.
A. Oh, yeah. I'd investigate that.
Q. Why would you investigate and follow up?
A. I would investigate.
Q. Why?
A. To reach -- to reach a compelling conclusion.
Q. Why would that be important?
A. Because a diagnosis explains the symptoms and prescribes a course of treatment. If the diagnosis is malingering, not only do your symptoms have to not conform to known patterns of illness, but you have to have other signs and symptoms of malingered illness. And that would be multiplicity of symptoms that don't conform to known patterns of illness, spontaneous concerns about the authenticity of your symptomatology, a relationship with one clinician who

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understands you and disparaging other clinicians who can't find out what's wrong with you, a use of superlatives and hyperbole in describing your symptomatology.
So there are things that you look for that malingerers have in common. A guardedness and an unwillingness to provide collateral history; "Who is the last doctor that saw you?"
"I don't remember, but my doctor told me this." Patients who use jargon in describing their symptoms rather than describing their discomfort and using laymans terms.
So those are more important than diagnosing malingering.
And to say that absolutely it's a diagnosis of exclusion, and you must do everything within your power to prove that the patient is not ill, that's not consistent with standard in medical diagnosis of history, physical information, and differential diagnosis.
Q. Most certainly your opinion disagreed with that person, doesn't it?
A. Well, I don't know who that person is or --
Q. I didn't ask who it was. I said --
A. Well, wait, wait, wait.

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Q. -- "certainly your" --
A. Wait, wait.
MR. CHAPMAN: Whoa, whoa.
MR. EADS: Don't argue with him.
MR. IHRIE: I'm not arguing with him.
MR. EADS: You are.
BY MR. IHRIE:
Q. I didn't ask who the person was.
I said: Certainly your opinion differs from that person's opinion, correct?
A. Whoever they may be, and whatever their credentials are, and whatever the quality of that publication -- which is not a peer-reviewed journal, it's not a medical textbook, it's not a tome; it's a magazine.
Q. And this is a conversation where you're giving us your opinion, right?
A. Well, no.
MR. CHAPMAN: Calm down.
THE WITNESS: Wait, wait. It's more than my opinion. It's what's taught in medical schools, it's what I teach in medical schools as an associate professor at Wayne State and as an assistant professor at Michigan State. That's how doctors learn how to diagnose.
Now, that's a journal for nurses. Their

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expertise may be different, their mandate may be more absolute. But I -- I disagree with that for the reasons that I gave you.
BY MR. IHRIE:
Q. So now tell me -- I appreciate that -- your right -- rather lengthy colloquy, but now tell me: What types of things do you ask a patient, and what type of tests do you give a patient when you suspect malingering?
A. Well, the questions I ask the patient would be the same questions I ask in taking the history. It depends on what the patient's presenting symptoms are and how they interact with me. And I wouldn't necessarily use laboratory tests, unless there were evidence to -- unless there were an indication to do so. So...
Q. Are seizures identifiable with laboratory tests?
A. Well, if a patient, for example --
Q. It's a real simple question, Doctor. Are they?
A. No. No.
MR. CHAPMAN: Don't argue with the doctor.
MR. IHRIE: I'm not arguing.
MR. CHAPMAN: Ask a question, let him answer.
MR. IHRIE: We don't have to move on if he says no.

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THE WITNESS: You are arguing with me, because a seizure is a diagnosis.
If someone has behavior that leads a doctor to suspect a seizure, the doctor can do a number of things. The first thing a doctor would do if he observes the phenomenon is to do a postictal neurologic exam or neurologic exam when the movements or the behavior stops. And there should be areflexia and an absence of certain reflexes.
If the reflexes are present, then it's likely that that was not a paroxysmal event or a true neurological event.
Q. Did he do that?
A. Wait, wait, wait. I'm not done.
Q. All right.
A. If the doctor is not certain, or the results are equivocal, in the immediate period after the behavior a blood test can be undertaken for prolactin. With paroxysmal events the brain chemical prolactin is released and peaks within minutes and is sustained for a period of 10 to 15 minutes.
So those are the kinds of things that a doctor can do. Obtaining electroencephalogram might be of some benefit, might be of some benefit if seizures are suspected.

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Q. Is there any indication in all the records that you read that Dr. Sherman did any of those things?
A. He did some examination in the period immediately --
Q. Any of the three things that you listed?
MR. EADS: I don't think he's finished.
MR. CHAPMAN: I don't think he's finished.
THE WITNESS: I think you got to let me finish. If you just want to argue with me, I'm going to keep asking you to let me finish until you do.
BY MR. IHRIE:
Q. I'm trying to get --
A. You say you will. You say you will. Whatever the goal of your endeavors is is of little interest to me. You asked me a question, I'm going to answer it, if you let me.
Q. I will let you.
A. That's what you keep telling me, but then you keep interrupting me.
Q. I'm waiting.
A. Well, let's see if you mean it.
And -- he did an examination. He did a postictal examination.
Q. I'm sorry?
A. He did a postictal examination, because he said he told the patient to do something, the patient

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responded. That's inconsistent with a seizure and that ruled it out.
Q. Anything else?
A. That's all he wrote. I don't know what else --
Q. What did the postictal examination consist of according to the records?
A. He gave the patient a command, the patient followed it.
Q. So he asked him -- what was the command?
MR. EADS: Just for the record, Doctor, which note are you reviewing?
MR. IHRIE: I'm sorry?
THE WITNESS: I'll tell you in a minute. The same note to which I referred before, the note that's listed as a late entry to June 23, 2014, which is actually a June 17.
"I went to see this patient, who was being observed in the medical unit for questionable seizures. I observed him fluttering his eyes in what was certainly not a seizure, but was most likely a poor attempt to feign one."
So he considered that the eyelid fluttering was not consistent with a paroxysmal event.
"I shook his shoulder and told him to sit up, at which point he suddenly stopped the eye

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fluttering behavior and exclaimed, 'What's happened'."
So giving the patient a command, and distracting him by touch, and having the patient respond, is inconsistent with a seizure.
Q. And it's your testimony that is a sufficient -- that is a sufficient test, whether it be neurological test or whatever test you want to call it, that is sufficient to rule in or rule out a seizure?
A. In that instance it wasn't the test, the sufficiency of the test, it was the sufficiency of the response.
Now, I could do that test. If the patient didn't respond, and I did nothing else, that might not be sufficient. But if the patient did respond --
I don't think you should put it up there anymore. I think -- you keep dropping it.
MR. EADS: I know.
BY MR. IHRIE:
Q. I thought it was your testimony that eye fluttering can be from all sorts of causes, correct?
A. It can. I just said that that was Dr. Sherman's inference. I didn't say that that was consistent with my understanding, but that's what he wrote.
And wait, wait. You got to let me finish. You said you would. Okay.
But certainly touching the patient, and

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giving him the command, and having the patient stop the behavior and follow the command, would be inconsistent with a seizure. And if the patient acted in that way, that would be sufficient to demonstrate that what was being observed was not the product of a seizure.
Q. I guess my question is: David never said or acted like he was having a seizure, so why would the doctor presume that he's trying to feign a seizure?
A. I think you asked me that a number of times. I think I answered it a number of times. And I don't want to respond to your guesses when you say you guess that that's what's on your mind. But I'll try to satisfy your mind by telling you that this note says, "I went to see the patient, who was being observed in the medical unit for questionable seizures."
So when the doctor was called, someone -- I don't know who -- was questioning whether the behavior that they were observing could have been due to a seizure, and that patients who malinger, or patients who have seizures, don't necessarily use the word seizure, or don't say, "I'm having a seizure," whether they are or not.
So I'm not sure -- I'm not sure why you have a hard time reconciling the fact that David

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Stojcevski did not refer to a seizure, but the doctor was concerned that he might have been having one given the behavior, and conducted a test that effectively ruled it out. What's the big deal? Why are you spending so -- I mean, you can spend as much time as you want on anything, but why you're spending so much time on it -- I'm sorry, Harold. I didn't mean to interrupt you.
MR. PERAKIS: No.
THE WITNESS: No, go ahead.
MR. PERAKIS: No, quite frankly, you interrupted me, but nevertheless...
THE WITNESS: I never said I wouldn't. I never said I wouldn't interrupt you.
MR. PERAKIS: Fair point, I guess.
THE WITNESS: Don't guess.
BY MR. IHRIE:
Q. Do you see anywhere in the records where Dr. Sherman ever asked who identified, quote-unquote, seizure-like activity, or inquired as to the basis of why he was brought down?
A. I don't recall.
Q. Did you see anywhere in the medical records where, even though the director of nursing knew that he had been taking benzodiazepines and that he had been

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engaging in either hallucinatory or delirium behavior, depending upon how you define those two --
A. You mean delusional behavior.
Q. -- delusional behavior, and with the other symptoms that you shared, did you see anywhere in the records where Dr. Sherman ever saw David again?
A. I don't think so, no.
Q. Did you see anywhere in the records where David was ever diagnosed with anything?
A. No, I don't recall seeing a diagnosis.
Q. Did you see anywhere -- anywhere in the medical records where the psychiatrist on call ever saw David?
A. No.
Q. Did you see anywhere in the medical records where David was ever -- we know he wasn't diagnosed, at least that's your opinion -- where he was ever treated for any diagnosed problem?
A. No, I don't recall. I don't recall any treatment being administered.
Q. What --
A. Other than observing him.
Q. What -- you would agree, would you not, that the symptoms of malignant catatonia may overlap with symptoms of other illnesses, other physical or mental problems?

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A. They may.
Q. And you would agree that your opinion -- well, strike that.
Why is it that David died, in your opinion? Strike that.
What did David die from, in your opinion?
A. "What did David die from?" I thought you weren't going to end a sentence with a preposition.
Q. I apologize. Don't tell my wife.
A. Or your Latin teacher.
David died of --
Q. Sounds a little stilted to say, from what did David die, but I will say that.
A. That's how Winston Churchill spoke.
Died from irregular heartbeat due to electrolyte imbalance.
Q. He died from irregular heartbeat, you say?
A. Or cardiac arrhythmia, the two.
Q. Is that a heart attack?
A. No. Heart attack is a coronary artery occlusion.
Q. So tell me the physiology of what he died from.
A. Well, the balance of sodium, potassium, and calcium in the blood supports an environment where nervous tissue that goes throughout heart muscle can stimulate the heart to beat in a manner that is regular and

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coordinated, so the ventricles contract and the atria contract, and the ventricles contract and the atria contract. And if the balance between sodium, potassium, and calcium in the blood is disrupted, the conductive tissue that monitors that process malfunctions, and either the heart beats in a dysfunctional way, or in an irregular manner, where it will beat and stop and beat and stop. And it may stop, or it may beat so rapidly that it loses efficiency.
Q. And what test was it that you looked at that caused you to conclude that? Any one test?
A. No, just -- just the way -- the way what happened to him was described, and the way his behavior was described.
Q. Well, who described what way that happened to him?
A. The documentation in the medical record.
Q. The documentation in the medical record?
Did the documentation in the medical record indicate any type of dehydration?
A. Well, they talked about a weight loss.
Q. Who's "they"?
A. The medical record described a weight loss.
Q. So what's the answer to my question?
A. "Who's they?" The medical record.

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Q. No, is the --
A. Well, that was your question.
Q. Okay.
A. You interrupted me, and you asked me that question. So anyway, if you want to ask me a question, I'll answer. You want to interrupt me and ask another question, then I don't know what question --
Q. Go ahead.
A. -- to ask (sic). So what do you want me to do?
Q. Go ahead.
MR. CHAPMAN: Come on, guys, let's --
THE WITNESS: Why don't you just whisper to him.
BY MR. IHRIE:
Q. Is there anything in the medical record that indicates that he had -- that he was dehydrated?
A. There was some suggestion that he had lost a huge amount of weight over a relatively brief period that was un -- that was unlikely, and -- but there were descriptions in the record that he ate or drank intermittently. So it's not clear that there's any basis to conclude that he was dehydrated.
Q. Did you read the autopsy report?
A. Yeah. Yes.
MR. CHAPMAN: He answered, "Yes."

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THE WITNESS: Yeah, I did, yes.
BY MR. IHRIE:
Q. Oh, okay. So you say you did read -- was that my question?
A. Yes. Yes.
Q. All right. And did you read the portion of the autopsy report that talked about the test that caused the medical examiner to conclude hypertremia (phonetic)?
A. Hypertremia? What's that?
Q. Dehydration.
MR. CHAPMAN: I'm going to object to form and foundation. I don't know what you mean by "test."
BY MR. CHAPMAN:
Q. Test of one of David's fluids.
MR. EADS: I'll just object to the -- I'll make the same objection, thinking back on the testimony.
THE WITNESS: Do you have a copy? Remember we discussed that the copy that I have --
MR. CHAPMAN: Isn't good.
THE WITNESS: -- the labs are half off the page. And I remember where you and I talked about this.
MR. CHAPMAN: I should have a copy for you.

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THE WITNESS: You gave me another copy. I don't know where it is. I don't know if you gave me -- I don't know if you scanned it or if you copied it, but I remember you printed it out.
MR. CHAPMAN: I have a copy here.
THE WITNESS: Yeah.
MR. CHAPMAN: I have a copy here. It has just my writing on it. Could I give it to him?
There you go, that's the lab values. The writing is my writing.
THE WITNESS: Yeah, because we had this.
MR. CHAPMAN: Yeah.
THE WITNESS: And I remember we printed out another copy of this --
MR. CHAPMAN: Yeah.
THE WITNESS: -- but I don't know where it is.
MR. CHAPMAN: The pencil/pen writing is mine, so...
THE WITNESS: Yeah. Okay. So -- so yeah, there was an elevation of sodium with a reference range of 135 to 145. This was 162. So 17. -- 17 -- nano milliliters.
BY MR. IHRIE:
Q. And do you know the significance of that reading?

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MR. EADS: Just object to form and foundation. Significance relating to what? Just a high sodium; is that what you want to know?
THE WITNESS: Yeah, that's an elevated value for sodium.
BY MR. IHRIE:
Q. And what is the significance of that? What does that indicate?
MR. EADS: Same objection.
THE WITNESS: Well, that indicates that there's more sodium than should be present in the blood; likewise, there's more potassium than should be present in the blood.
BY MR. IHRIE:
Q. And does that come from --
A. And actually, this is vitreous?
MR. CHAPMAN: That's vitreous fluid.
THE WITNESS: Yeah, this is vitreous.
BY MR. IHRIE:
Q. Yes.
A. And potassium is elevated.
These reference ranges might not be accurate for vitreous. Chloride, and the glucose was 26, so his blood sugar was low. His BUN was elevated. And his creatinine was not necessarily elevated, so

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there may have been some kidney abnormality.
Q. So -- and I'm not trying to -- I'm not sure I understood the -- your testimony with respect to what the cause of death was.
MR. CHAPMAN: Objection: asked and answered. He said an arrhythmia due to an elevated sodium.
MR. EADS: Join.
THE WITNESS: Elevated potassium.
BY MR. IHRIE:
Q. Okay, all right. So, all right, he wrote it down.
So due to electrolyte --
A. Good thing he's here.
Q. Yes. Due to electrolyte imbalance.
What causes electrolyte imbalance?
A. Kidney problems, too much water intake, not enough water intake. This is, I mean...
Q. And so do you have an opinion as to what caused David's electrolyte imbalance?
MR. EADS: Just object to foundation.
MR. CHAPMAN: I would join as well and indicate that the doctor is not here as a pathology expert; he's here as a psychiatric expert.
MR. IHRIE: He's testifying on why David died.

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MR. CHAPMAN: You asked him the question. He's not offered as an expert in pathology.
MR. PERAKIS: He's still testified to it.
MR. CHAPMAN: I'm sorry; is there a question on the table?
BY MR. IHRIE:
Q. I think the question was: Do you have an opinion as to why he had an electrolyte imbalance.
A. Let me -- you know, it's not clear, given the unusual pattern of the imbalance and the laboratory values. If this was simple dehydration, his blood urea nitrogen is elevated, his creatinine is not quite as elevated. So that suggests that it's other than dehydration that caused this -- this imbalance.
Q. Well, what did you mean then when you said, "Catatonia can become malignant and life-threatening due to poor nutritional intake, dehydration, hyperactivity, and symptoms may progress to severe dehydration and death. This would be more consistent with the course of Mr. Stojcevski's illness"?
A. Those are some of the possible outcomes in malignant catatonia, and those are the possible risks of morbidity. In this case, given the odd pattern of elevation of sodium, but extreme elevation of potassium, and elevation of BUN without a -- without a

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proportional elevation in creatinine, raises some questions that make it difficult for me to determine --
Q. Well, why did you say "This" --
MR. EADS: Whoa, whoa, whoa. He didn't finish.
BY MR. IHRIE:
Q. Were you finished?
A. -- make it difficult for me to determine why this pattern of electrolyte abnormality appears. It doesn't seem to be consistent with dehydration.
MR. CHAPMAN: And I will again raise my objection. He's not here as a pathologist, and these questions are inappropriate. We're not offering him here as a pathologist.
MR. IHRIE: I'm just reading his report.
MR. CHAPMAN: No, his report says nothing about creatinine, says nothing about potassium, says nothing about...
BY MR. IHRIE:
Q. Your -- so what I would like to understand then, when you said -- when you were just testifying a moment ago, you said, "Well, in this case."
Well, when you use the phrase in the last paragraph of your report, you say, "This would be more

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consistent with the cause of Mr. Stojcevski's illness."
A. Yeah. Malignant catatonia.
Q. And you indicated, "It can become malignant and life-threatening due to poor nutritional intake."
Did he have poor nutritional intake?
A. Wait. It can be.
Q. I understand it can be.
So my question to you is: Did he have poor nutritional intake?
MR. CHAPMAN: It's already been testified to.
THE WITNESS: We talked about that. We talked about that two hours ago.
BY MR. IHRIE:
Q. Did all of these symptoms: "poor nutritional intake, dehydration, hyperactivity, and symptoms may progress to severe dehydration and death," is it your opinion that that's what happened?
MR. EADS: Objection: foundation.
THE WITNESS: No, it's not. Because that electrolyte pattern is not consistent with dehydration.
BY MR. IHRIE:
Q. So is your opinion changing now, because of what you

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just read two minutes ago --
A. No.
Q. -- from what you wrote in your report?
A. No, no. No, what I wrote in my report are common symptoms of that illness, and stating that that illness is a more compelling conclusion. But not every illness encompasses every symptom of that illness.
Q. Do you have an opinion as to why he died?
MR. EADS: Same objection.
MR. CHAPMAN: Objection: asked and answered. He said "an arrhythmia."
BY MR. IHRIE:
Q. Oh, I'm sorry. All right.
A. I'll accept it.
Q. Did you read the expert report of Dr. Baden, also one of Mr. Chapman's experts?
A. Are we done with the autopsy?
Q. Yes.
A. No, I don't think I received Dr. Baden's report.
Q. Well, he concludes -- I'll just read you -- it's one sentence. He concludes after reviewing all of the medical records, ostensibly the same ones that you looked at, he says, "It is my opinion based on the autopsy materials that I have reviewed, that the

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immediate cause of Mr. Stojcevski's death was dehydration contributed to by starvation."

So we have one expert saying "dehydration contributed to by starvation," you indicated it was a heart problem caused by an electrolyte imbalance, and we have a medical examiner who concluded that it was benzodiazepine withdrawal syndrome, and we have one or two other opinions that are out there, too.

Do you have an opinion as to why so many people that look at the same thing come up with different opinions?

A. Well, first --

MR. EADS: Hang on.

MR. CHAPMAN: Wait, wait. I'm going to object as to form and foundation. You mischaracterize all of those, and I don't even know where to begin. It's such an absurd question.

MR. IHRIE: Note your objection. State your objection.

MR. EADS: Hang on.

Join the objection first on behalf of my clients.

Now we can take an answer.

THE WITNESS: My answer is that the exact mode of death was not part of what I was asked to

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consider or what I was asked to opine -- on which I was asked to opine.

Now, you asked me a series of questions; I answered as best I could based on my understanding of what -- of what the autopsy said, and based on my understanding of what those -- and you asked me about the laboratory. That's really not why I undertook this analysis. I undertook this analysis to reach a diagnosis of his condition towards the end of his life.

BY MR. IHRIE:

Q. Okay. Is it your opinion -- is it your testimony that you don't have an expert opinion as to what caused his death?

A. To the degree that we've been discussing about cardiac arrhythmias and electrolyte or pathologic findings, no. That wasn't the focus of my opinion.

The focus of my opinion was the diagnosis of his condition and what was responsible for the behavioral changes that he manifested while he was in the jail.

Q. Do you agree that benzodiazepine withdrawal, the symptoms of it and the duration of it, depends on a number of factors that include the following: the length of time that a person took benzodiazepines?

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A. We talked about this an hour ago.

Q. We're going over something slightly different.

A. Well, that's not any different.

Q. I'm going to go through a list.

A. Well, that's not any different than anything I've already answered.

Q. All right.

A. So I'll refer you back to my earlier discussion. Just so -- at the late hour I want to make sure that everything I say is consistent.

So you can look up the last time you asked me that, and I'll give you the same answer.

Q. No, I want you to answer now.

A. I'm not going to do that.

Q. Well --

A. Because I already --

Q. -- you're refusing to answer my question?

A. I already answered.

MR. CHAPMAN: He answered the question several times.

THE WITNESS: I have --

BY MR. IHRIE:

Q. Then your attorney can make an objection, and the objection will be dealt with.

A. He's not my attorney.

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Q. The attorney who hired you --

A. You know better.

But you referred to him as my attorney. He's not my attorney.

Q. The attorney who hired you can make his objection. You have an obligation to answer the question.

A. I answered the question.

Q. You have an obligation to answer it now. If it's asked and answered, that's a --

A. Are you giving me legal advice?

Q. Yes, I am giving you --

A. You are.

MR. CHAPMAN: The doctor has the right to stand by his prior answers. That's what he wants to do. That's what he's doing.

BY MR. IHRIE:

Q. All right. Let me ask a different question then. Does it depend upon the method used to take -- that a person has taken benzodiazepines?

A. The method?

Q. The method: injected, oral?

A. I would say that that would have a lesser effect on the timetable and manifestation of the symptoms of an abstinence syndrome.

Q. Does it depend on any underlying medical or mental

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health issues?
A. I would say that there would be some very unique situations where a mental health issue might affect the manifestations of benzodiazepine withdrawal physical condition, if someone had some underlying cardiac illness or neurologic illness, then that may be some part of the determinant of how the abstinence syndrome manifest themselves.
Q. Does it depend at all on whether or not the patient was abusing other drugs or alcohol concurrently with benzodiazepines?
A. Well, "other drugs" is kind of nonspecific.
Alcohol, alcohol acts in a manner that is similar to benzodiazepines, and the profile and nature of an alcohol abstinence syndrome is somewhat different. So the alcohol use would have to be significant and severe.
But again, the symptoms of -- we've already discussed this some time ago. The symptoms of an alcohol abstinence syndrome occur -- occur earlier rather than later.
Q. Explain this to me, if you can: Almost every article, including those from the National Institute of Health that I have read, indicate that -- including this one I'm looking at -- indicate that the benzodiazepine

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withdrawal timeline indicates that the first symptoms occur somewhere in the area of one to four days after cessation of use; then the acute, or what is generally speaking in the literature that I have read called full-blown withdrawal, occur -- it peaks around week two and then begins to subside; and then post is a third category which could go on for weeks, months, or years, but typically the symptoms, to some degree, subside.
My question is: Why is it that almost every single article that I read says that the symptoms peak somewhere in the area of a week to two weeks --
MR. CHAPMAN: I would object to form and foundation. Mischaracterizes the evidence in the literature.
BY MR. IHRIE:
Q. -- and your testimony is that it peaks within just a matter of a day or two.
A. Well, again, I think you're mischaracterizing what I said. And I -- and we've discussed this extensively. I've repeated myself more than once. And what I said was that: With short-acting drugs, the abstinence syndrome occurs sooner; and with longer-acting drugs, the abstinence syndrome may emerge somewhat later.

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And that period of one to four days, I believe I used the term 12 to 24 hours at the short end, and I believe 72 to 96 hours at the long end. And if you take the time to go back in this record, you'll find that that's what I've said consistently.
Now, the fact that the abstinence syndrome can last for a week, that's not been consistent with my 40 years of clinical experience in dealing with benzodiazepine dependence and withdrawal as an addiction specialist. And if the literature -- if you're characterizing the literature as saying that, I think that they may be discussing some of the long-term effects of benzodiazepine withdrawal, that is lower seizure threshold, increased anxiety, lower tolerance for anxiety, lower tolerance for change, disturbances in sleep and other functions. And those things -- the first patient I ever detoxed from benzodiazepine told me that it took her six months to a year before she felt like herself after stopping these medicines.
So I wouldn't necessarily disagree that there's a prolonged secondary abstinence syndrome, but in terms of a delirium, a risk of spontaneous seizures, I believe that that risk diminishes after the first -- after the first week.

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Q. After the first week?
A. That's been my clinical experience.
And, I mean, I'd be willing to examine the great body of literature to which you're referring. They -- I don't think you're accurately characterizing what the literature says or implies.
MR. IHRIE: I don't believe I have any more questions.
THE WITNESS: He was done an hour ago.
MR. CHAPMAN: John, do you have any questions?
MR. EADS: Yeah, I've got a couple.
EXAMINATION
BY MR. EADS:
Q. Can malignant catatonia-afflicted patients die without dehydration?
A. They can.
Q. And do people who suffer from malignant catatonia, do they experience pain?
A. From the behaviors that they manifest, it's our inference that they do not. Maintaining postures against gravity for prolonged periods of time, anyone would find that uncomfortable. These patients don't appear to experience that discomfort.
Furthermore, a delirium by definition is an

21:11 **inability to take in information, process it, and act**
21:11 **on it. That doesn't mean external sensory**
21:12 **information, it also means internal information. And**
21:12 **older reports of catatonia that were imprecise in many**
21:12 **ways but were richly descriptive, describe catatonic**
21:12 **patients maintaining postures even though they**
21:12 **experience pressure sores or bleeding or other**
21:12 **sequelae that we would consider to be physically**
21:12 **uncomfortable. They don't seem to experience it or**
21:12 **complain of it or alter their behavior because of it.**
21:12 MR. EADS: All right. That's all I have.
21:12 MR. CHAPMAN: I have no questions.
21:12 MR. IHRIE: Okay.
21:12 MR. PERAKIS: I have nothing. Thank you.
21:12 MR. CHAPMAN: We're done.
21:12 MR. PERAKIS: We're done.
21:12 Thank you, Doctor.
21:12 MR. EADS: All right, Bob, we're all finished.
21:12 MR. GAZALL: Thank you, gentlemen. Have a good evening.
21:12 MR. CHAPMAN: For the record, I guess we should indicate it's 9:15. Do you guys owe the good doctor some money?
21:12 MR. IHRIE: Yeah, we do.

(The deposition was concluded at 9:12 p.m. Signature of the witness was not requested by counsel for the respective parties hereto.)

STATE OF MICHIGAN)
COUNTY OF OAKLAND) ss.

I, Mary Jo Power, CSR 1404, in and for the State of Michigan, do hereby certify:

That, prior to being examined, the witness named in the foregoing deposition was by me duly sworn to testify the truth, the whole truth and nothing but the truth;

That said deposition was taken down by me stenographically at the time and place therein named, and thereafter transcribed via computer-aided transcription under my direction, and the same is a true, correct and complete transcript of said proceedings;

Before completion of the deposition, review of the transcript was not requested. If requested, any changes made by the deponent (and provided to the reporter) during the period allowed are appended hereto.

I further certify that I am not interested in the event of the action.

Witness my hand this 1st day of June, 2018.

Mary Jo Power

MARY JO POWER, CSR-1404
Certified Shorthand Reporter
State of Michigan
My commission expires: December 12, 2018